THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON THURSDAY 8 MARCH 2012.

COST REDUCTION STRATEGIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Professor RAYMOND PLAYFORD AND **Professor DENISE FASSETT**, UTAS FACULTY OF HEALTH SCIENCE, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Forrest) - Thanks for coming along. I will explain how the process works basically. Everything that you say is recorded on *Hansard*. That then becomes part of the public record. We will prepare a report in due course and we may use your evidence to support our report. If there are things that you think should be discussed in private or in camera you can make that request and the committee will consider that. Usually it is things that should not be in the public arena and you have to justify why in that circumstance but otherwise it is all part of the public record of the hearings. It will appear on our website usually a few days after the hearings. This is the media as well who have an interest in health. There may be some more coming. Try not to feel intimated by all that.

We have the one term of reference looking at the health cuts and we have had a range of evidence from a range of people. A lot of it is a bit broader than just the cuts to elective surgery and we have heard from some of the clinicians particularly concerns about accreditation and access for trainees and that sort of thing to provide enough exposure to certain things to maintain registration or maintain accreditation of not only the facility but also individual practitioners. We also thought it be would helpful to hear the academic viewpoint about the impact of the cuts and where you see these cuts potentially heading.

Did you want to make an opening statement about overall views or would you just like us to ask you questions?

Prof. PLAYFORD - I will give a few general comments perhaps of what I have seen. For those of you whom I have not been able to meet yet, I have been here for just a year. I came over from the United Kingdom where I was in a similar position to that which I am in now so obviously I am familiar with the UK system very well and I am learning what has been happening in Australia. One of the useful things also is my membership of the Medical Deans of Australia and New Zealand because then I get a perspective of what is specific to Tasmania and what is more general and these have similar aspects from the nursing side.

I think some of the areas that I have been speaking to the chief executives in the hospitals about comes down to a lack of clarity as to what a university teaching hospital is and what is it core duties and how does it differ from a district general hospital that does not have students. Certainly the model that we are used to in the UK is a university teaching

hospital that has a tripartite mission. That is obviously excellent clinical care but that also should be underpinned by teaching both at the undergraduate and postgraduate level and evidence-based research. If the university is just dealing with basic laboratory science that is really separate from what is going on in the hospitals but if we are going to change practice then working together I think is a core aspect that a university teaching hospital should be working on in that regard.

I think there exists a symbiotic relationship between the hospitals and the university. We both should be in a win-win situation. Certainly we are obviously benefiting from patient exposure and we are very grateful for that but also on the other side of course is that the reason that many of the clinicians come to these hospitals is that they enjoy going teaching and the vibrant aspect of being in a research environment, so hospitals win from that side as well. The model where the UK is different to over here is around the financial aspects of how a hospital gets its money, and I know it is very complicated over here with so many different streams. It is slightly simpler in the UK. What used to happen, in the most simple terms, was that in the UK the hospitals used to get a single pot of money which they were meant to be delivering on an education agenda, research agenda, and a clinical service.

CHAIR - Was it just the hospital, Ray, or was it the hospital and primary health services?

Prof. PLAYFORD - I am talking about just the hospital for this particular bit. And what happened of course was that when things got tight the hospital used all of the money that should have been going to teaching and research to deliver their front-line services, and you can absolutely understand why that was, but that was not the plan of the Government. So the way that it was got over was to disaggregate, so they got three separate funding streams and they had to report on how they were delivering on those three streams. That to me makes discussions much simpler because we know what we are talking about. One of the issues that we have in my current role is how much money our hospital is getting, if any, for looking after our students, and there is a lack of clarity around that because with regard to DHHS funding it comes in as a single pocket. The DHHS are delivering money which is meant to be helping for the education and research agenda, but because it is not clear then that causes some areas of confusion and uncertainty. So I think that we monitor things that would be very useful for us to look at, and then we can have sensible discussions about whether it is the right amount of money or not, but until we are clear how much it is, it is very hard to have those sorts of areas.

CHAIR - Just on that point, before you move on, Ray, were you looking at blurring, I guess, of how much money there is for front-line services, how much there is for research and how much for support for students? I guess the same happens with nursing to a certain extent as well, but when that is clearly defined it comes to pinch from Peter to pay Paul or whatever. When we see cuts like we are seeing here, and we are seeing cuts to the front line, does that have a flowthrough effect even more so to the other areas?

Prof. PLAYFORD - No, because they are separate. They are assigned and there are different groups, and in fact what has happened now is that the research funding for the hospitals, rather than just being given to an individual, was put back into a single pot and they had to apply for it through a central organisation that was purely looking around the research area, again to keep the separation from the clinical service. In percentage terms it is relatively small to the overall budgets of the hospital, but nevertheless is very

important. So that was why you needed to have separate ones. It does not mean you cannot move stuff around, but at least you know where you are starting from, and then you have to have a discussion about the appropriateness of it, because some appointments will be delivering on all three agendas, so there is no problem with having some of the money coming from each of those three pots if that post is delivering on them.

The other general area which you are all very familiar with of course is that Tasmania has a population of about half a million and so that means that you are not going to see many of the rare conditions. If you are looking at the London environment with six million of course we get many more of those. But with a population like that it is going to be very hard to have super-specialised services being delivered at each and every hospital around the State, and so for the rare ones we have to find a way of doing services across the whole of Tasmania. I am not sure that we are quite there yet. I know there is a will to do that, but I am not sure it is working completely well at the moment, and something I would like to see is the clinical networks working more efficiently. The purpose behind the three THOs is to help give a local flavour but they should be working in an integrated way as well, hopefully through that common chairman, to make sure that there is cross-working across all the different sites.

CHAIR - Ray, how would you define 'rare conditions' in a Tasmanian sense? We know that neurosurgery, for example, is only done at the Royal, and then the top level of intensive care is only done at the Royal.

Prof. PLAYFORD - I am not saying that everything should be done in Hobart.

CHAIR - No, I am not saying that. I am just asking what sort of area, whether it be Hobart, Launceston or Burnie, it doesn't -

Prof. PLAYFORD - There are the specialised things around neurology and, as you mentioned, neurosurgery, perhaps a very complicated cardiothoracic type of surgery, and again perhaps complicated pancreatic-type surgery, the things that are extremely difficult to do and are not day in and day out, because we know there are lots of figures that if people are going to have to do complicated operations, the more they do of them the better the patient outcome is at the end. So it is better to have fewer people doing more of them than just people doing one every couple of years.

CHAIR - Are there some things we shouldn't even try to do in Tasmania at all?

Prof. PLAYFORD - I think we should be collaborating with the mainland where appropriate. I don't know whether you use the term mainland.

CHAIR - Yes, we do - the big island to the north.

Dr GOODWIN - Do we do much of that already, collaboration with the mainland?

Prof. PLAYFORD - There is some relationship with Melbourne, and I think that is appropriate, and there are some other ones, and I am not quite sure, but for example the continuous intravenous feeding that you have to do for people that do not have enough intestine, and again that has to go in a much bigger spectrum than even within London.

We have to go in much broader areas. So I see no problems with working with the other hospitals outside the State.

I think you were asking in the general area about the medical and nursing school, and of course we also do para-medicine, and pharmacy is also very important for us. I am pleased that over many years we have established a very high prestige status. People want to come here, and that is a very important thing to do, and it takes a long time to build up a good reputation but a relatively short time to damage such a reputation, so we need to make sure that the message that we are giving, where appropriate, is showing the successes that are occurring, and we do have good relationships with all of our hospitals, and I think that is important, though we must make sure of it, and with all of these complexities, because everywhere - this is not just a Tasmanian-type issue - there are peaks and troughs of finances and changes that have to be done with the health service delivery. The health service budget will never be enough, no matter how much money we put into it, because there are always extra things that can be done, and can be done when you move into the preventive care as well, and so we have to find ways of being efficient, and that is something I know that should be being looked at at the moment, and I know that is being done in the hospitals.

Dr GOODWIN - Ray, can I just go back to that point you made a minute ago. You said something about us having a prestige status now.

Prof. PLAYFORD - Yes.

Dr GOODWIN - What is that in and how did we get that?

Prof. PLAYFORD - We got that by making sure that we take bright students who can succeed, so we have a very good success rate, and we make sure that they get a good experience. Of course the students talk to other students about where they should go and they do enjoy their experiences. One of the advantages that we have in Tasmania is of course we have people who are in Hobart and they can go up to the Launceston clinical school and the north-west, and these are very different sorts of experiences. I am quite keen to make sure that all of the students get some flavour across the whole of the State, but for those who want more time in one I think that is very good that they like to do that. The other area which is a concern for us is around the internships that we hear about a lot. That is a potential concern, certainly for nursing and for medicine. We need to be sure that we are training the correct number of doctors and nurses. That does not mean, certainly in the nursing side, that every single nurse that is trained in the University of Tasmania can have an internship in Tasmania. That is not the model that we would be looking at. And similarly we also need to be looking at workforce planning in the longer term. We know across Australia because of the age of the nurses out there that there is going to be a major shortage of nurses in a few years' time, so we must not let the ebb and flow get out of synchrony and to stop people being trained through now because they will be needed by the time they are ready to be out there on the front line. There may be a gap, and we are certainly seeing that in the UK. We had that situation with the training of respiratory consultants, where at one stage there were too many of them and so everybody was giving up doing respiratory medicine, and then suddenly, partly because of things such as AIDS when there was a much bigger need, and tuberculosis coming back again, we realised we didn't have enough so we were rapidly

trying to train them. And so workforce planning I think is a problem, but that is Australia-wide.

Dr GOODWIN - Do all our medical students do their internship here in Tasmania?

Prof. FASSETT - Not necessarily. I am not sure how many leave.

Prof. PLAYFORD - The vast majority do. We do have some, of course, who are international students and I think a sensible number of international students is an important thing to have because what we need to make sure is that our students and also the local population have exposure to people from different backgrounds. It really enriches the whole environment. I think UTas is being very reasonable in the number of international students that we are taking. One of the things that we are having to look at, of course, is that elsewhere around Australia they have a much higher percentage of international students and that is something that I think could be a potential concern but that is not something that we are contemplating.

CHAIR - Some of those go back to their own country for their intern year, don't they?

Prof. PLAYFORD - Yes. That is what I am saying.

Dr GOODWIN - Do we have a set number of places?

Prof. PLAYFORD - Yes. We have a capped number of medical student places.

Dr GOODWIN - Then, out of that, are there so many intern places as well?

Prof. PLAYFORD - Well, the intern places are not linked with the number of students that we get in, although obviously we have been trying to make sure that that occurs. One of the differences between the model over here as opposed to the UK is that the equivalent of the intern places are funded in a different way in the UK and the first year is actually under the general responsibility of the medical school as opposed to once they qualify, which is the situation here. They are not actually the responsibility of the university anymore, although obviously we take a paternal type of approach and try to help them. At times of financial concerns, of course, then the hospitals will be saying can we actually afford to have these internship places or not and now we are trying to work with the hospitals to help them look at some innovative ways of helping them with that. For example, the ones that want to pursue academic careers, getting them so that they can do a PhD at the same time at a slightly younger age of internship, to try to stretch them out a little bit. I think that could be quite exciting. It is one of our biggest risks, so to speak, or sensitivities, although we are managing it at the moment.

Dr GOODWIN - So the number of intern places varies?

Prof. PLAYFORD - Yes. It can be altered by the hospital providers outside of our control and that's one of our biggest concerns.

CHAIR - As can be graduate nursing positions. Do you want to speak about that, Denise?

Prof. FASSETT - Yes. It is similar. Obviously we enrol students into a Bachelor of Nursing and we have them enrolling in Hobart and Launceston. There is no guarantee or expectation that when you graduate, one would do a graduate year in Tasmania. Like all young Tasmanians or, indeed, Tasmanians from all walks of life, they may be considering some life choices and career moves. I think one of the things that is beneficial for Tasmania is the fact that a number of graduates leave and gain significant experience in some of these areas that we've been talking about previously, in specialty areas that we don't necessarily offer for postgraduate nursing here, and they return. I think in nursing there is and always has been a culture of some mobility and that's been to our advantage in this State.

CHAIR - Regarding the percentage of mature age and Australian uni-type graduates or straight out of years 11 and 12, in Tasmania does that differ from other States?

Prof. PLAYFORD - Yes. We can talk about it generally, the whole of the health workforce and what it will be like in the future, but different universities are doing it in different ways. Still people are basically coming through from school straight into university; some of the other universities are saying that you have to do a first degree first of all and there is some debate about the pros and cons, although we are very happy with the outcome of our doctors as they come through as are the hospitals where they are going. Also, what people are graduating with is really an area of fractionation across the deans-type world because certainly one of the universities is moving forward to offer an MD over four years whereas an MD for many other people is something very different to what they're giving and that's a graduate entry type where in four years they will end up with the equivalent of an MBBS and they've done a little bit of research so they're labelling that as an MD.

CHAIR - In four years?

Prof. PLAYFORD - Yes. So there is confusion at the moment and there is not consistency across those things. That's one of the areas that we are going to look at. At the moment that's not a model that I would particularly like because I think an MD is a research-type area and much more getting people to come through with an MBBS and then considering a PhD-type approach but we will have to review it because we will have to see how everybody else is doing. There is a certain attraction for students, of course, to come out with an MD and that is what happens in the US so we are certainly looking about that. The old model of what a nurse did, what a doctor did and there was nobody in between was the old-fashioned model and we have the healthcare assistant and we also have the nurse consultant-type models coming through. One innovation in the UK was the introduction of the nurse endoscopist and again in gastroenterology, as specialists we spend of our time sticking tubes into patients and that is a skill that we have to learn but it does not actually have to be a consultant that does that, particularly if you are just looking into the stomach. The UK and some other places have suitably trained nurses to go down that route and that frees up the time of the consultants to do the more complicated procedures. That is the sort of innovation that we should be looking at and I know that we are trying to work with people to do that.

Prof. FASSETT - Health Workforce Australia is looking into this area at the moment and into these extended roles and providing streams of funding to assist projects develop those particular areas and training programs that will support those areas and I guess one

of the things from having budget cuts or pushing us into thinking about the way services are delivered is that it also means in a time of reform that we are thinking about the way that health professionals work in addition to the way that service is delivered.

That gives us sometimes opportunity to work more collaboratively inter-professionally across disciplines and to really think about the models of care that we currently have. I think it is an interesting time all round because we are in that space at the moment of talking about certain restraints and cuts in health but we also have Health Workforce Australia looking at how we can build capacity in clinical placements. Indeed in Tasmania in partnership with the Government and other healthcare providers we are looking at a number of projects to develop that space. I think what we have done for a long time in Australia - and I am talking about in nursing and in midwifery here - with the transfer of nursing education to some extent, although we have worked closely in partnership we did go our separate ways and I think now is the time that we have to look very carefully and closely at how we can work together again because indeed there are obvious links and connections between education and healthcare delivery.

I think that is really around your point as well, Ray, when you mentioned perhaps in the UK this notion of a university teaching hospital and having frameworks that support education and research. In that respect we are in a space at the moment where there is opportunity for innovation and to rethink the way that health care should be delivered and indeed who should be delivering it.

CHAIR - There is so much at risk that I think you need to be careful how, for want of a better word, this is sold. If you are saying that we expand the role of nurses who are cheaper in the light of significant budget cuts, that we will get the cheap option, put a few nurses into doing this job, clearly that is not the message that we want to be sent. The nurses that are skilled up are quite obviously capable and suitably qualified and trained and educated to undertake these roles. Are you saying you see the cuts as an opportunity to look more at this?

Prof. FASSETT - No, I am saying that we are in a climate in Tasmania at the moment and elsewhere of health cuts but certainly since I have been working in a senior leadership role in nursing and midwifery I have not seen this space before where we have funding available to assist us to look at capacity building in clinical education. In some of the areas - nurse endoscopists that you were talking about - of course that is not the message. Nurses are highly skilled and when we graduate nurses they pursue careers in many areas. This is one area and it does not just involve the skill of endoscopy. It is really that it extends their role as a registered nurse and that registered nurses can be thinking about other areas that they may be able to practise in.

CHAIR - Where is this funding coming from?

Prof. FASSETT - Health Workforce Australia.

CHAIR - It is Federal Government funded?

Prof. FASSETT - Yes.

Prof. PLAYFORD - It is really the extended role around endoscopy. We know that Tasmania is one of places that the colonoscopy waiting lists are an issue. You can just keep increasing the number of standard gastroenterology consultants but they will only spend a certain proportion of their time doing that area that is needed but what you should be getting the people to do who are super-specialised - and that includes the nurse endoscopists as well - is making sure that they are at the top of their skill chain that they can deliver on so that everybody is performing efficiently and the other roles, which somebody else can do, should be done by that appropriate person.

That is not sort of a pile them high, sell them cheap approach at all. That is making sure people are doing things. There are actually lots of advantages in a nurse endoscopy list because that is absolutely all that they focus on when they are doing that. If you have your consultant, gastroenterologist, quite often they are having to think about the ward round and everything else that is going on as well.

CHAIR - They can go and do the colectomies when they have determined it is necessary -

Prof. PLAYFORD - Yes, exactly.

CHAIR - as opposed to endoscopies.

Prof. PLAYFORD - Exactly. The other area I am quite keen on talking about -

Mr HARRISS - Before you go off into a different stream, with this notion of capacity building that Denise talks about is there the possibility of resistance, if you like, from doctors?

CHAIR - The turf war?

Mr HARRISS - Yes. I have heard about it. Is it a reality?

Prof. FASSETT - It is always a possibility. In terms of resistance to a changing culture and climate, I guess, of what everyone's role is and scopes of practice I have seen over the last few years an increasing commitment by all health professionals to thinking more inter-professionally. The resistance I believe is now diminishing as we all focus more on perhaps being more patient centred and considering the outcomes of the people that we are caring for. That requires us to think more about being in teams, of actually examining the way that we have different models of care.

In terms of the resistance to nurses you will be aware that doctors have been quite vocal about any number of roles that nurses or any other health professionals might take, as are nurses of their colleagues as well, but I could not pinpoint in Tasmania and say that there is a block or a resistance at all. Why I made the comment that it is an interesting time is that I see people coming together to discuss it and probably in ways that I have never seen before. That, to me, is heartening.

Mr HARRISS - It seems then, from what you have both said, that this provides an opportunity at a time of budget cuts so where else in the world does this sort of thing occur and why weren't we walking these paths in Australia a long time ago to get appropriate health delivery at possibly less cost?

Prof. PLAYFORD - Because we are all on the same learning curve. This occurred in the UK about five years ago. I was having these same sorts of discussions in my previous role in the UK and these were the sort of solutions that we were doing. We were saying that we could not keep expanding on the NHS budget so we have to become much more efficient and all of these sorts of discussions that are occurring in Tasmania have been occurring in the UK and they are weathering that storm.

CHAIR - In the face of budget cuts that is when the discussions started in the UK?

Prof. PLAYFORD - Yes.

CHAIR - It was in the face of budget cuts?

Prof. PLAYFORD - Yes. Just a slightly different sort of spin on it from what Denise was saying, what we are seeing is a much better inter-professional team approach to clinical care. That always occurred but it is actually occurring much more now so that, just as an example, on the ward round it is not just the consultant that goes around and makes all the decisions, particularly if you're looking at something like rehabilitation because you have all the different specialists - the occupational and the physiotherapists - that have their own particular areas of expertise and it's that team approach that we need to be looking at.

Mr HALL - Do you think things are simpler in the UK where you just have a single funder because you've only got the one Federal government, if you like, whereas we tend to have our mixture of jurisdictions? Do you have an opinion on the way that we should go here?

Prof. PLAYFORD - It is more complicated over here. I'm still getting to grips with it.

Mr HALL - I bet you are.

Prof. PLAYFORD - As well as all the different streams that are coming into the State hospitals, you also have the big private sector providers. Most people in the UK actually go and see their GP, their primary care person, and that is the gatekeeper who then does the referrals through to the hospitals. With the models that are usually done with the GP fund-holding type of models, every time he or she refers them off to hospital, that has a financial impact on their budget.

CHAIR - On the GP's budget?

Prof. PLAYFORD - Yes, because he or she only has a certain amount of money and every time it goes out some money has to go with that patient.

CHAIR - The money follows the patient?

Prof. PLAYFORD - Exactly. Over here, I don't think the model is quite the same. I don't know the model well enough to know whether that will mean that it's easy for people to just flow through to the hospitals. It's very hard, once you've got a referral, to turn people away because once you've got that referral letter, somebody has to deal with the

situation, whereas in the UK it's that gatekeeper-type role and I don't think it's quite the same over here. So I think that is one extra area of complexity.

CHAIR - Are you familiar with New Zealand's area health service model?

Prof. PLAYFORD - I'm not, I'm afraid. I think one of the things that will be quite useful is how is the Medicare local going to work with the THOs and I think that relationship will be very important because as far as the patient's concerned, once they get sick and they have to go to a hospital, they come back down into the community, so really there has to be a seamless type of approach and I'm hoping that these new systems will be useful for that.

One other thing that I was going to mention, which I am used to and which I developed in my old role, is a clinical academic, and that is a person who is a leader in the clinical service delivery, helping to lead what's going on in the hospitals but, at the same time, actually having good research capability. I know that the hospitals are interested in doing that and they want to work with them on that. So, again, in fact it's blurring those boundaries between where does the university start and where do the hospitals come. Again, to show willing again, because I do think it's very important, I'm now on the Medicare Local Board and one of the reasons I wanted to be on there is to make sure that there is representation about teaching and research as well as input from primary care, and I think that's for the future; making sure we work together.

CHAIR - The THA Board?

Prof. PLAYFORD - Yes. The university is putting an application - well, they are going in as individuals, of course, but people with a university background - I have been encouraged to apply to those because, in a way, what we are trying to do is an academic health system across Tasmania, and that is the sort of model that I would like to see where everybody has signed up to this idea of excellent clinical care underpinned by evidence-based research and high-quality teaching under the CPD mode as well. So, yes, we are trying to get involved.

CHAIR - Just to get back to the funding model, in Tasmania with the primary health care, I don't know where that is going with Medicare Local but that has been and I think is still intended to be predominantly funded by the Commonwealth. We've got the acute health services which are going to go from 60 per cent and 40 to 40:60 so that the Commonwealth pays 60 per cent. Mental health is still out there on its own and dental health, similarly. In the UK, you have the one bucket of money that flows with the patient from the GP to the hospital -

Prof. PLAYFORD - Yes.

CHAIR - and so there's no distinction between primary and acute services; is that how it works there?

Prof. PLAYFORD - No, it's not quite like that because, as you've probably seen on the news, the NHS under new reforms brought in by the government is causing a lot of concern. But certainly, yes, there is one bucket of money that is coming through from the primary care because it is GP fund holding and they will do commissioning. But we

also have the strategic health authorities that have been taking an oversight of hospitals where services are delivered. Again one of the areas that has proved very successful in the UK is making sure that patients get to the place where they will get the best treatment in the so-called drive-by approach. If you have a heart attack in a particular road in London and the ambulance arrives, it would not necessarily take you to the hospital just down the street. It will take you to the one which has the expertise, and we have shown that people have better survival by doing that. And so that is the sort of model that we are talking about here.

CHAIR - So that happens in London where you have quite a dense population?

Prof. PLAYFORD - Yes. And maybe we are in a very different situation with a rural agenda and we have to do horses for courses around them. Of course, when are people are sick and need urgent treatment they need to get it where they are locally. The question is how do we deliver things which are much rarer and make sure they see somebody who really knows about that.

CHAIR - Perhaps on a slightly different track, with the cuts to elective surgery in particular, those front-line cuts - there is a range of cuts being made across health, particularly focusing on the front-line cuts - do you see that having any impact on students, nurses or medical students in getting enough experience and that sort of thing? Will it have a detrimental effect?

Prof. PLAYFORD - The feedback we are getting at the moment is that it is not having any significant detrimental effect on the student training, but that is something that we obviously want to keep and the same is true for nursing.

Prof. FASSETT - Yes, we definitely would be needing that, and we are in conversation about that, so that we would need to keep a close eye on the availability of clinical places for our undergraduates and also look at our postgraduate specialty areas where people are undertaking courses. There is no evidence at the moment for us to be able to report, so we need to keep a watching brief on this.

Prof. PLAYFORD - The model that we have at the moment is that for the clinical years the students can elect to stay in Hobart, go up to Launceston or go over to the north-west, and the reason that we can do that is that there is basically a full portfolio of activities wherever they are to get them suitably trained. Of course if things changed, just as an example, cardiothoracic surgery, or if something that they need some exposure on did not occur around one of these sites, then we would be having to look at changing the model to make sure that they get the full experience. We are not in that situation at the moment, but it is certainly something that we would need to see, so again it would be dependent on how the hospitals deal with their financial situations.

CHAIR - That is the question then. I think a difficult discussion needs to be had about what we provide where; are we going to continue to fund health services that specially provide good outcomes for people, which ultimately is what it is all about. If decisions were made that we weren't going to provide everything everywhere - and admittedly we don't now but there are some things that we do - it may need to be reviewed. Is there flexibility within the nursing training programs and medical programs to adapt to that?

Prof. FASSETT - Absolutely, and one of the things that I think we need to remember is that the largest campus and the main campus for nursing is in Launceston, so clearly we have always thought that we have enough flexibility to provide all of our undergraduates the experiences that they require in order to fill the requirements of the course, and that means that our students do travel and they may have some of their education on the north-west coast, they may have some of it in the south, so there is that mobility across the State, so that we look for where the students' preferences are and also where we can provide that experience for them. Sometimes we use a system of allocation and students will need to go where we know they need to have the experience.

CHAIR - Is there a kind of student nurse that would be exposed to every aspect of, say, neurosurgical nursing as well as orthopaedic?

Prof. FASSETT - No. The course is accredited under broad standards, and they can meet the requirements of the course, and we have to be mindful and we have to align the accreditation standards and so on with the learning outcomes that we need, so we do require students to move around. Also, we believe that for our students, particularly in the north, having an experience in the south and being in the Royal Hobart Hospital and then to have other experiences in rural and regional areas is enriching for them. It's also good for the community.

Prof. PLAYFORD - Yes, some rotation of students is absolutely a positive because if you're just fixed in one hospital you will see a limited number of doctors and how they do things. By seeing other consultants in the same specialty somewhere else, you see a slightly different way, which I think is a very positive thing.

Prof. FASSETT - We've done a lot of work in this area because of the perceptions that the main campus is in Launceston and, therefore, people enrolling and families enrolling their children would always be asking us the question of whether they can do everything in Launceston. Not necessarily and for them to understand that for many reasons that have a particular history that's where we have the largest majority of our students located on the Newnham campus and we have a small campus in Hobart. I'm making that point because it's unusual. You usually see the larger campus in the capital city.

Prof. PLAYFORD - We're quite happy with that.

Prof. FASSETT - We're very happy with our Newnham campus and I should make the point, because I didn't in the beginning and I wasn't thinking of that but I have moved out of the role of head of nursing. In introducing myself, I didn't say that and, as an acting head, is Professor Isabelle Ellis at the moment.

Prof. PLAYFORD - The other area for workforce planning, which I think is a concern, is after that internship year and the training posts they are going through again, we can get them to a certain level at the university until they go through to that internship level but then, of course, there is still a long training period before they become consultants. Many of them are going outside of the State, which is not a problem, but they're going out to get the extra training because they may not be able to do that here and what we have to do is try to find ways either to keep them here or certainly to attract them back if we want to keep our workforce for the future. Of course, that's also particularly relevant in the rural agenda for the primary care. It was very successful; last year, it was going up

and getting exposure to that but that will not necessary translate into them staying as primary care practitioners up there in the longer term. We need to make sure we find ways of training through the whole scheme.

Mr HARRISS - So those comments are linked to the budget cuts and the likely or possible impact in the future. Is that where you're coming from?

Prof. PLAYFORD - I think that could be a concern because the training roles are important and, again it comes back to what is the fundamental role of a university teaching hospital and that is also getting the workforce training throughout.

Mr HARRISS - Have there been any forecasts or projections made about what the actual number impact would be in terms of people, positions and opportunities for training?

Prof. PLAYFORD - I haven't heard any specifics about Tasmania but this was one of the areas that is an Australia-wide issue because what we have done over the last decade is have a large expansion of medical student numbers, but that isn't the same as opening up the number of additional training posts and certainly in the rural environment, they just aren't there for them to be trained through in those intermediate grades. So I think that is one of the areas of sensitivity where we need to do some workforce planning in the future. Certainly for here because the students are having an excellent experience and they say that they're enjoying being over here, is how to either keep them here or to bring them back again.

Prof. FASSETT - In nursing and midwifery, one of the ways that we might think about bringing them back in the future has been through a necessary partnership with other health providers in Australia so that we can offer postgraduate courses. For example, for the university to run some of its postgraduate courses, let's pick emergency nursing, for example, they were not viable courses because Tasmania would only require small numbers of specialist nurses in these areas in the workforce and so the enrolments were very low.

When I took over as head of the school we had very small numbers of postgraduate nurses and yet this is a major area of requirement in the State. So in partnership we have been able to now offer our courses into New South Wales and indeed other areas of Australia and in Tasmania and have put a large number of postgraduate streams on line and available within Tasmania which I believe has had a positive impact.

CHAIR - Which areas of specialities?

Prof. FASSETT - We have pretty well covered a very broad range of areas including rural nursing and rural and community nursing, emergency nursing - all of the specialities - rehabilitation. I think that has been a positive.

Mr HALL - Whilst you have given positive vibes about some of our nursing people going away and getting experience and coming back -

Prof. FASSETT - Yes.

Mr HALL - We have also had evidence that we have the oldest nursing workforce in Australia at the moment -

Prof. FASSETT - That is right.

Mr HALL - and anecdotally because of the budget cuts we are losing a lot of our youngest and brightest persons. You know and I know a lot of those probably who do not come back.

Prof. FASSETT - Yes.

Mr HALL - Is that a concern to you?

Prof. FASSETT - It is a concern to me. If we are losing nurses, as you are saying, our youngest, our brightest and they are not coming back then that is a concern. As a university and working in partnership with health we have a responsibility to attract those individuals and indeed Tasmanians back to the island.

Mr HALL - How do we do that? That is the question, is it not?

Prof. FASSETT - Well the attractions are often firstly in postgraduate. Many nurses want to pursue careers and we know have available those options for them to live and work in Tasmania and pursue a career that would take them to any number of areas in nursing and midwifery.

Also we know that people are attracted to positive aspects of the workforce and we have an opportunity, as Ray has been saying, to build a culture of education and research that is certainly evidence-based, that attracts people to come and work with exciting teams that are also not only delivering high quality care but are working in areas of research and innovation. I think that you can grow that at home, you can start that innovation, you can built that capacity in research and education that creates an attractive niche area people come back to. There are many other things you can do in the workforce.

CHAIR - But if we have got to cut the number of nurses and nursing positions and frontline services, which is obviously the biggest way to cut money, because that is where your big costs are.

Prof. FASSET - Yes.

CHAIR - Does that then diminish the opportunities? As Greg has said, we are losing some of these people in spite of having the opportunity to train or do postgraduate studies interstate. Are they likely to think the way things are going we have fewer jobs in DEM or fewer jobs in theatre because we are cutting all this elective surgery and they will just go anyway?

Prof. PLAYFORD - This is an Australia-wide issue of efficiency. There is nothing wrong with having an efficient service. In fact it is a more enjoyable environment if things are running efficiently. In absolute numbers they may well go round but that means we should be making sure that we keep the best and encourage them and we are certainly

doing things such as honorary appointments for the university and getting in that teaching culture to make them want to come back.

Prof. FASSETT - And by continuing to attract people into careers where they want to do nursing.

CHAIR - At this stage you are not seeing this, almost a fear in a way, of not getting the opportunity to really pursue a career in Tasmania because what we are doing is slashing and burning and getting rid of services, so you are not seeing that flow? It is still early days because these cuts only started back in October.

Prof. FASSETT - Yes.

CHAIR - There was a slowdown over Christmas in elective surgery anyway so it is only as things start to ramp up. I know they are certainly coming to my office and other members' offices as well but these are people being put off from surgery so it is starting to bite now.

Prof. FASSETT - Yes.

Prof. PLAYFORD - What we can say is that the student recruitment this year has been very positive in the Health faculty, and so we are very pleased about that. And again part of that is not just whether there is a job at the end but also this is a place that people want to come to, and that is why we have to keep the reputation of the place. The other area that I should mention of course is not just medical students and nurses, but we have paramedicine, which is a very important course, and we are also looking at how we can work with other organisations in the allied health profession-type area. Dentistry is actually a big issue in Tasmania and we are looking at how we can get more students coming through and staying over here. At the moment it is unlikely that we could start up a new dental school on our own. It just wouldn't work, but we are looking at perhaps partnering with some of the other universities that do have -

CHAIR - Do you have a partnership with South Australia?

Prof. PLAYFORD - We do have some links, but we want a much bigger sort of area. Again, similarly with things such as physiotherapy and speech therapy we probably cannot start them all from nothing. By doing relationships with other universities I think that would be positive because again in some of these allied health professions we do have a shortage of them within Tasmania. If we set up an entirely new school, that would be filled relatively quickly and then what would happen to the follow-through students, so we are looking at relationships for that.

CHAIR - So if you had the opportunity to make some serious recommendations about health service into the future and there was a clean slate. Obviously you need to consider budget restraints otherwise, as you said, you could keep pouring money into the hole and it would all just be sucked in. What would you see as the best way to ensure that we get good quality service in Tasmania with people who are well qualified and want to be here, so we are not losing that expertise that you have talked about that we have? What do we need to do?

Prof. PLAYFORD - What I can say is how we did it perhaps in my UK experience, and that was we looked at things such as average length of stay for various procedures within the hospitals to see whether they were really benchmarking against other organisations. We have all sorts of cultures, for example, of bringing people in the day before so that they could then have their operation the next day. By stopping that you can get a much better turnover through your beds, which is a far more efficient way of doing it. The other thing that I am keen on - and it doesn't matter whether you are in a hospital environment or in a university environment - is making sure that people know what their job is and what the expectations are, and that comes around job planning so that everybody knows their roles and regular appraisals, which was certainly something that was highly efficient and was very beneficial in the UK environment, and something that we are doing in the university sector. I am assuming it is occurring within the hospitals as well. Everybody can be benchmarked and see whether they should be rewarded if they are doing more than the expectations, and if they are not doing what they are meant to be doing you have to find out why that is.

CHAIR - So the activity-based funding would drive that won't it?

Prof. PLAYFORD - Yes, it will, but again it goes down to this system. What I am used to is departmental job plans as well, so that we will deliver the following outpatient clinics or surgery lists and things, and exactly how you divvy up who does what again is an internal matter within the lead of that clinical service. That is how I am used to doing those things.

CHAIR - So in the UK then, if you are looking at who does what where, some GP practices, the whole big shooting match, they will determine we are going to do endoscopies but not arthroscopies or whatever, and the arthroscopies are done over in the neighbouring county or whatever, is that how they do it?

Prof. PLAYFORD - No, because those things would be done within the hospital, but you do get competitive forces and if they are not happy with the services that they are getting from one hospital they can actually move them to another hospital, so that does cause some risks around it. But that was also where the Strategic Health Authorities came in to do an overall oversight of how things were going.

CHAIR - There is an overall plan as to what is going to be done where.

Prof. PLAYFORD - Yes.

CHAIR – Is that for the whole of the UK?

Prof. PLAYFORD - Yes, the Strategic Health Authorities were doing that.

CHAIR - What decision-making power, I guess, is vested in the local GP practice? I think what we are talking about here is the area health service in Tasmania effectively.

Prof. PLAYFORD - Yes.

CHAIR - And the THOs that we now have three of because we can?

Prof. PLAYFORD - Yes.

CHAIR - How much power and decision making should be vested in them?

Prof. PLAYFORD - In some ways it doesn't matter where the funding is lodged so long as there is an agreement about what is the expectation; what bang do you get for your buck. So you have to say, if I am going to give or refer my patients to your particular hospital then we expect them to be seen within a certain time limit and we expect you to be at least at the average of the various figures that you can do for success in surgical procedures, et cetera and if that isn't occurring then there has to be a contract renegotiation. So you do get into contracting.

CHAIR - Who is accountable then, in that situation?

Prof. PLAYFORD - That would be with the budget holders or the GP or whatever context which is a time of change in the UK at the moment but the GP fund holder, if I could use those sorts of terms.

CHAIR - In our case it would be the THO?

Prof. PLAYFORD - At the moment I'm still trying to work out who is the purchaser and who is the provider because that's an area of slight confusion; who is giving the money when a patient moves from one to the other; who is purchasing and who is providing.

CHAIR - It seems to be the department to the purchaser if you look at the model that's being proposed. The smaller shrunken down department is the purchaser and the THOs or the area health services are the providers.

Prof. PLAYFORD - I have to be honest; it's a slightly confused model for me but that might be my misunderstanding of the situation. But there will be your Medicare Locals - they're going to be referring people to the hospitals - and then again, who is going to decide -

CHAIR - There's only one Medicare Local though.

Prof. PLAYFORD - But who is going to give the funding streams into those hospitals and how are those decisions going to be made? Again, if they're not being efficient, is there a system saying we're not going to do that in your hospital because you're failing so we're going to give it to one of the other hospitals. I am showing my ignorance here; I don't quite understand how that's going to change -

CHAIR - I think you're probably not the only one who doesn't really understand it.

Dr GOODWIN - I am not clear on how many actual graduates we have coming through the system. Can you elaborate a bit on that? How many places are there for those graduates?

Prof. PLAYFORD - In rough terms, because it does vary slightly from year to year, but we're looking at about 118 medical students and of those about 15 would be international. We have roughly 55 to 60 pharmacy students a year, which again, are a real asset. I think our pharmacy school is a very high prestige school and is certainly one

of our gems within the faculty. I don't know if you want to make any comment about the nursing numbers.

Prof. FASSETT - It's interesting in nursing because at the Newnham campus we run the three-year Bachelor of Nursing course and we have up to 300 places. Those places for the students are aligned with the clinical placement capacity within the State. Then we also have, in Hobart, a different model. It is still a Bachelor of Nursing but we run over two calendar years but it's the same course and we take 100 students into that course. In any one particular year there are fluctuations in terms of enrolments and in both those areas we haven't seen any fluctuations in Hobart. I understand that was one of the reasons why people were very much in favour of opening a campus in Hobart and I think, up until we opened the campus in Hobart, we saw people from the Hobart community decide to do nursing and leave the State. So they would make the decision to study elsewhere rather than travel north but of course a number would always go north.

That's the number that we take in and then, depending on attrition and for the end of the year, the graduate numbers fluctuates as well and you'd be aware that with the graduate places they also change and fluctuate considerably.

CHAIR - They have this year settled.

Prof. FASSETT - Yes, that's right.

Prof. PLAYFORD - Is that the sort of numbers you wanted?

Dr GOODWIN - Yes, and, in terms of what happens after they graduate, how many placements are available - training places or whatever they're called.

Prof. FASSETT - Although we work in partnership, once the students graduate and all of the places that are available are not within our area, so in nursing in any one year, depending on what is happening with the budget, will reflect the numbers of places that are available. What we can do in the university and with the government to respond to that is to look at ways of supporting new graduates in different models. We have certainly been looking at that in nursing, and that is where we would work in partnership, possibly, to have transition arrangements for students so that the university could be involved in that process. We don't have that yet, but we have been looking at it.

Prof. PLAYFORD - And with the medical students we can't 100 per cent guarantee that everyone has an internship place. There may be a small number that don't, but some of them were going abroad as well.

Dr GOODWIN - So do you need to have some capacity to be more flexible about the number of new students you take on, depending on what is happening in terms of their placements?

Prof. PLAYFORD - I think stability in that internship year would be in everybody's interest because it does cause uncertainty and, as people are getting ready for their finals, they need to know what is going to be happening. They also do an important role within the hospital setting. They are not just passive, they are actually doing a job, and some stability around what those numbers are would be very useful, because it is out of our control and that is one of our concerns. If there was a significant change in that, that would be a problem for us.

Dr GOODWIN - And you don't know until the end of the year, and then presumably you don't have a lot of time to then turn around and change the numbers of new students that you accept.

Prof. PLAYFORD - There is a five-year lag.

Prof. FASSETT - Yes, it is the lag period, and I think that is why when we were asked earlier regarding perceptions in the community, will I decide to do nursing and so on, we were talking about making a decision about your career for three years' time and people now understand that things change rapidly in this environment. They are also aware, as Ray was saying earlier, that the average age of the nurses is around 47 and there is data to support that we are facing a nursing shortage yet again in the future. I think it has always been that sort of leaking bucket analogy. If you try to make adjustments based on short-term decisions then we don't have a long-term future. I think it would be very shortsighted and I think we should be very positive and encouraging of our Tasmanians to still look at nursing, pharmacy, medicine, any of our health professions, as a career option. We will need this workforce into the future, and we need to be creating a positive climate around what the future might hold regardless.

Prof. PLAYFORD - There are no plans for a major expansion in the undergraduate area, well certainly with the medical students they are capped anyway and we think that -

CHAIR - Or reduction?

Prof. PLAYFORD - We don't have any plans for a reduction now either. What we are doing is looking at the expansion of the post-graduate area, which is something that Denise talked about. That really falls into the continuing professional development area and I think that is something that we can be very strong on. I think that is what our health work force needs, just a general upskilling for the future.

Prof. FASSETT - And we are not in nursing and midwifery increasing the numbers.

Dr GOODWIN - So are just staying at the same level basically?

Prof. PLAYFORD - For the undergraduates.

Prof. FASSETT - For the undergraduate and for the postgraduate, that is something for - as I said, it is a consideration that others in Australia can enrol in our courses, so it is difficult to determine how many Tasmanians may wish to enrol in particular streams. The most important point is that they are now available.

Dr GOODWIN - So that is sort of a potential growth area, the postgraduate side of things?

Prof. FASSETT - There is some capping to postgraduate places that we need to consider and so at the moment, being higher education, we would have to say that we are hoping in the future there will be potential for growth but right at this moment we have got capped places.

CHAIR - The School of Nursing in Launceston is renowned around the country for its interactive learning, is it not?

Prof. FASSETT - For its simulation, yes it is. We have had considerable success and a great deal of exposure now, both nationally and internationally, with simulation. That is a really big area that we are very keen on exploring in the faculty related to quality and safety and educational research.

Prof. PLAYFORD - The other area that we are hoping to do on a faculty-wide basis is to encourage school children to come in and see what it is like, what careers in health are like, so we are looking at some possibilities at the Domain site because the youth houses has taken ownership of it and I think that could be very exciting to bring people in, particularly from backgrounds of course that may have had no exposure to going to university. I think that would be good.

In the continuing professional development, just saying how good we are I will never miss an opportunity for that, we have had the new paramedic course, which is basically upskilling people that are already in the role, making sure that they are absolutely at the top of the game. That is proving an extremely popular course.

Similarly, the School of Pharmacy has an Australia-wide online scheme for continuing education for the drug industry, drug reps so to speak, making sure that they are upskilled. That is an area that I think is right for appropriate expansion.

CHAIR - I think we are out of time. Thank you very much for that. It has helped get a bit of background and the longer-term view is important as well.

Prof. PLAYFORD - If anybody would like to visit the health faculty, you are always welcome.

Prof. FASSETT - We have had quite a lot of visitors to the simulation centre. I thought you might have -

CHAIR - With Tas Leaders I went there last year.

Prof. FASSETT - Yes, I thought you might have been.

CHAIR - It is worth a visit. It is just fascinating.

Prof. PLAYFORD - They are very scary, those models.

CHAIR - I know.

Prof. FASSETT - In Hobart we will have opportunities in simulation for visits as we further develop that.

CHAIR - Thank you for coming.

THE WITNESSES WITHDREW.

Ms JANE HOLDEN, ACTING CEO, SOUTHERN AREA HEALTH SERVICE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - We appreciate your coming back. We know from when we first spoke to you before Christmas the cuts had really only just been announced and we are starting to implement them. Also we have had all of you here together, divide and conquer - no, it was not that at all. It is really to give you an opportunity to focus on the Southern Area Health Service in particular and how things are going there.

We are very aware that the slowdown over Christmas generally in elective surgery has meant that the impacts of those cuts at elective surgery level are probably not really felt until after that, but I know the Royal has experienced high occupancy recently so we are interested in how things are going with the budget savings - staffing numbers, that sort of thing - and how likely you are to meet the targets, and what it will mean if you do not, particularly as there is an expected further saving required for next year.

Ms HOLDEN - Just to recap, the Royal carried forward a deficit of $33 million. It did not actually carry the number forward but the Royal finished the 30 June 2011 financial year with a $33 million deficit and, while we did not have to carry that cash forward, quite clearly the infrastructure was supporting that $33 million.

We were assigned a $27 million budget saving which was our share of the $100 million so the challenge for the Royal was $60 million over this year. Although we did not actually know that specific number, we certainly knew from about this time last year that we were going to head for a deficit and we had to do something about that, so a lot of work started on what kind of strategies could we put in place to reduce our expenditure from about March of last year so that by the time we actually got to the budget level we had quite a number of programs that we had already been thinking about having to put into place anyway. In fact it started on some of them.

CHAIR - Had you made some savings leading up to the end of the last financial year?

Ms HOLDEN - We had certainly slowed down the expenditure rate although, like with all hospitals, if you begin a strategy it can take a couple of months to actually get traction but we started seeing the impact of that pretty early on in July, that those strategies we were putting in place were actually saving money.

CHAIR - What were those ones specifically?

Ms HOLDEN - They were about looking at staff that were in areas where we had had growth without additional funding or resource to support that and whether or not that need was still there, and we looked at reviewing the staff where they were allocated. We looked at how we were managing our good nurse graduates and junior doctors - were we actually letting the old ones go to take on the new ones - those kinds of things. We introduced new rules around overtime, new rules around rostering leading on to a much better project for the next financial year around rostering but looked at how we were ordering our supplies and actually completely changed that so that we could really only order on consignment, except for something signed off by the CEO. We also looked at how we were recruiting staff and put in some processes that made sure criteria were met

to ensure that for the staff we were putting on the vacancies were there and were actually needed and we have done a review prior to this replacement, and those sorts of processes. So there are lots of systems reviews going on and those were some of them.

CHAIR - Do you have the actual staff head count at the end of June last year and where we are now?

Ms HOLDEN - I do. I think the reduction is around 120 FTEs.

CHAIR - Since 1 July this year?

Ms HOLDEN - Since 30 June, 120. Some of the things we've done about those is we have worked out with people what it is they are trying to achieve and looked at whether technology or people can help them achieve those goals and sometimes putting in a better system and a better IT system or better technology means they don't need that sort of resource.

Going back to your question, on 1 July there were 3 323.75 FTEs. On 8 February there were 3 152 FTEs.

The other thing we did was that we looked at the way we were using casual pools of staff. There had been a growing pool of staff on the casual pool and what we introduced - and it is a very important people in hospitals because they allow us to flex up and down and do those things. What we want is a pool that is working very closely with us, at least providing four shifts a month, that have attended all of their training programs, that are up to date in all of their annual criteria and they have to be supported with staff. A number of those staff actually hadn't been working for quite some time and when we contacted them, they didn't want to meet those criteria and defaulted. So some of those are people who were not actually participating actively in the workforce that also were reduced. As we had a system in 2010-11 where some graduate nurse roles were supernumerary to the actual full-time equivalent budget and we needed to, as we met our commitments to those, we made sure that new graduates were put into graduate posts that were part of the establishment, not supernumerary to that.

There were a number of small things that added up to that. There is no one area that we targeted or anything like that. By and large, the number of medical FTEs has in fact grown over that year. There has been some reduction in management, clerical and health professional, a very small reduction in the health services award of 14, senior executives and 3 in BMOs and in nurses and graduates, 96.

CHAIR - It was 171 from the figures that you gave if my maths is right. You're saying that 96 for the nurses are those and the medical workforce grew.

Ms HOLDEN - Yes, I'm happy to table this document.

CHAIR - That would be helpful.

Ms HOLDEN - In actual fact, this one says that it's actually declined, sorry, from 192 to 378 in the medical practitioners award.

CHAIR - From 192?

Ms HOLDEN - From 392.

CHAIR - Oh, 392.

Ms HOLDEN - From 392 to 378. It had grown; in July last year it was 353 so it grew. In July last year, it was 353 and in February this year it is 378. It actually peaked.

CHAIR - Have these medical specialist positions been vacant for a while? Where have we seen the growth? Do you know?

Ms HOLDEN - Well, sometimes it is a more cost effective solution to employ more staff. So, the example for that is we would write through rosters as part of the organisation. We were paying high levels of overtime to junior staff and it was smarter to bring more people on and not pay them overtime so we had a high head count but a lower cost. So, where it was smarter to bring more people on we did and where people weren't being fully utilised we took opportunities through resignations. We didn't make anyone surplus or anything. As resignations came through we didn't replace those and we managed the pool.

CHAIR - What is the dollar figure of those savings?

Ms HOLDEN - What we are forecasting is that we will meet around $40 million of that $60 million deficit.

CHAIR - That's $20 million.

Ms HOLDEN - Yes.

CHAIR - To carry into next year; is that what will happen with it?

Ms HOLDEN - Well, I can't answer that because I don't know how the budget is going to be allocated next year but we are still working at that other 20 and we've still got the last quarter to go so we may do better. We do not, at this point, believe we're going to meet budget.

CHAIR - Are you happy to table that, please?

Ms HOLDEN - Yes.

CHAIR - As far as the management and clerical positions are concerned, what areas were they in?

Ms HOLDEN - They are senior management roles. We changed that structure largely and that is where those positions are coming from. The SES positions changed.

CHAIR - With the ongoing reform of health with the THOs and the Medicare Locals being established, starting 1 July, will that have any implications for your staffing arrangements?

Ms HOLDEN - In so far as what?

CHAIR - Numbers. Would there be any additional staffing costs. The Government is talking about shrinking the department down to a small lean machine - I think they described it along those lines. Obviously there is going to be the boards that are going to have costs associated. What cost would the southern area health service wear as a result of these changes?

Ms HOLDEN - If there is a change in the structure of the department there might be more costs if we have additional services. For instance, the southern areas recently picked up statewide dental services. It's not reasonable to say that's a growth in costs for the southern area; it's just a movement into that area. So, subject to whether any of those changes happen, the only costs that I am aware of will be around some minor support for a board. We need to work through exactly what that will be but there will be a board, which doesn't exist now and will need some support. I think the ABF will require some clerical support to ensure that we are coding and counting and doing those things. We are developing an IT solution to support that work, but it will require some -

CHAIR - So we could see an increase in your FTEs again in the clerical area?

Ms HOLDEN - Yes. I don't believe it is going to be huge.

Mr HALL - Just to clarify, Jane, in this last quarter of this financial year to go, are you saying you might claw back that $20 million?

Ms HOLDEN - We won't claw back $20 million. We may do slightly better than that, but I don't believe we will claw it back.

Mr HALL - You have undertaken all these mitigation measures as you outlined, and you have had to do it. What effect has it had on front-line service delivery in your view? Has it been a negative at this stage, or have you been able to meet the needs of people?

Ms HOLDEN - Most of our savings have come from the way we work, so they have been about systems development, about processes, about rules around calling in overtime, approving extra shifts, approving leave so that we don't get seven people all wanting the same days. Actually putting systems into place. By far most of our savings have come from that area, where we buy our stock from, how well the pharmaceutical programs are going, getting people aware that when they are ordering pathology tests that there are some high-cost ones and are they ones that are actually going to help enhance the diagnosis or the treatment. It is a model that we have described inside the Royal as a back-to-basics, going back to what we do and making sure what we do is the best, most cost-effective -

Mr HALL - And that model is sustainable in the short, medium and longer term?

Ms HOLDEN - It is absolutely the way we should be working.

Mr HALL - Is there more flexibility to make further savings in that regard?

Ms HOLDEN - I think all organisations look for continuous improvement, and that is something that we will look at at all of those processes, and as our information systems get better and better those processes can get slicker and slicker. It is my expectation that we will always look to improving the systems that we use and the decision-making trees that we support, making sure that they are actually facilitating the core business of delivering health services.

Mr HALL - Could I say that perhaps the enforced financial constraints have had a positive effect in some ways in regard to this, it has forced some change?

Ms HOLDEN - I don't think anyone wanted fiscal constraint, but it does focus the mind so if we have to save money how would we do it and what would we do. We have worked with the patient at the centre and tried to work from as far away from them as we can to make sure that the things we do around the patient, the business of running these great big hospitals, the hotel services, the way we purchase our paper, our laundry, our medical supplies, our non-medical supplies, are all tight, all of our other costs actually have really good processes around them. The way we spend capital, all of those things, the way we roster our staff, the rules we put around that, so that at the end of the day what we are looking for is the patient having the right resources they require.

Now we have had to also restrict access to elective surgical services, and that has had an impact on the frontline for our staff and our patients, so it would be wrong to leave a message that we have saved it all that way. By far the bulk of it has come from there. We are predicting about $7 million from the savings of the elective strategy.

Mr HALL - So that impact on the elective surgery area is going to continue? Is it going to be exacerbated as we move forward, given there has already been an impact now? In your view will that move forward and have a multiplier effect?

Ms HOLDEN - There is no evidence to date - recognising these things were put in in November, and Christmas and January are slightly -

Mr HALL - Yes.

Ms HOLDEN - There is no evidence to date that we are doing less work even though we have reduced 23 sessions so the volumes are looking pretty much the same, both in terms of day cases and inpatients and we have not seen any growth at this point in the emergency demand either.

If we could keep that going that would be very good. I am not sure that that is going to be the case but we are constantly looking for ways to deliver what we are doing now but slightly differently to try and get greater productivity.

Mr HALL - I think it was mentioned before with winter coming up and perhaps a flu season might cause some logjams?

Ms HOLDEN - I think the bed numbers we have got we can cope with them at the moment and we watch them all the time. I look at those bed numbers three times a day. Our job is that we flex up and down - it is the nature of being a public health service. We do get things you cannot predict.

Our averages are one thing, the day to day running is quite another so the recent pressure that you referred to was about presentations to the emergency department and 40 per cent would be admitted and 60 per cent would go home. That is the normal thing that happens pretty much across every emergency department everywhere, that is the sort of ratio.

For some reason - there is no common diagnosis, there is no common age, there is no common locality - that almost flipped so 60 per cent of the people that presented needed admission and 40 per cent went home. In fact the numbers of attendees at ED dropped but more of them needed to be admitted than could be discharged.

That is what happens when you talk about an average, it is one thing, but we went through a period where the situation was tight. Now we did get through that and we have just this Monday opened additional beds in our acute older persons' unit.

That has taken significant pressure off the other and we will watch that for the next couple of weeks and just see that that is stable but I think it would be wrong to say that we have got, in terms of current capacity, the capacity to deal with a pandemic.

CHAIR - What does that do to your budget savings strategies? You say you are possibly going to be $20 million short of the requirement that was set for you and, even though there are blips in that one instance where there was a 60:40 flip and then opening up this acute older persons' unit, will that have a negative impact on that?

Ms HOLDEN - No, the costs are accommodated. I am forecasting knowing what I am doing, you know knowing that I am opening this unit.

CHAIR - Yes.

Ms HOLDEN - What we have done is we have closed one ward in the Repatriation Hospital and opened it in the Royal Hospital. The reason was a number of older patients were going from the Royal to the Repat and back to the Royal - not quite stable enough to be out of the acute hospital but thought to be well enough but too acute to be in rehabilitation.

What we have done is open an acute older persons' unit in the Royal. We still have the other unit in Peacock so that they are new beds; they are transition beds which we think will actually create a much better flow for our older patients. In fact we are very excited that that was a path that needed to be completed.

We had a couple of weeks where we had high demand and those beds were not opened so we were actually even tighter than we will be now.

Dr GOODWIN - Jane, can I just go back to that point you made a while ago about no evidence to date that you are doing less work even though you have has reduced sessions. Does that mean you increased your productivity?

Ms HOLDEN - Yes, it does. That is exactly what it means. The potential for some productivity gain was there and I have to take my hat off to the surgical teams. They have stepped up to the mark and filled those gaps.

CHAIR - That must mean, in some respects, that it was operating inefficiently previously.

Ms HOLDEN - There was some productivity clearly because they have addressed some of that. Look I think everyone would admit, and there is probably more in terms of system support, and I do not think anyone felt that they were at maximum levels but again, referring back perhaps to the idea that when you get a bit tighter you look for other opportunities, that the surgical team has looked for these opportunities and because their focus is about getting patient services out there they've exploited those opportunities to the benefit of patients. But it's early days so I don't want to make -

CHAIR - When we talked to Gavin Austin in the north-west, because it's obviously a smaller facility with less throughput he told us that he's had to cut the number of hip and knee replacements, particularly, because they're quite costly procedures and it was one of the quickest or simplest ways of achieving those cuts. You're saying that that's not actually happening here; you're not seeing that reduction in service because you've been able to see that productivity gain; is that the case?

Ms HOLDEN - I know the north-west quite well and I think it has been lean for a while - they've been working very efficiently, in my view. They were able to do that and have less impact on waiting lists that were actually quite low. So waiting time hasn't been as dramatically affected as the actual procedures going through. Here, we didn't particularly target a procedure. When we looked at the sessions, we looked at a number of factors. Obviously, the acuteness of the patient waiting was one of them, the length of time that patient had been on the waiting list and any perceived view that failure to move them up would default them into emergency. So we did that across all specialties; we didn't just do it on one.

CHAIR - So you spread the load?

Ms HOLDEN - We were able to spread the load. Clearly, the team stepped up and filled in the spaces where there was some ability to be more efficient. That's exactly what it appears that they've done during that period.

CHAIR - What have your waiting times and waiting lists done since June last year?

Ms HOLDEN - I haven't got that information with me but in some specialties, like endoscopy, they have come down because we've listed in that area despite the budget strategy so those have come down. In other areas, it actually depends on the churn. So because we're doing the same sort of volumes, it will be growing at the same rate as it ever was or staying steady.

CHAIR - We heard from Gavin where the orthopaedics has been affected, obviously, that we moved from 9 per cent to 18 per cent.

Ms HOLDEN - Yes.

CHAIR - So you're not seeing that sort of thing happening in the south?

Ms HOLDEN - Well, we are. The volumes that we're putting through now are the same as they were but that doesn't mean that the waiting list isn't growing, because it is. What we need to do is get to a sustainable position where patients that come on the waiting lists are offset by the patients that go off the waiting list and we're not at that point yet. Until we deal with that hump we will grow the waiting list.

At this stage, we are not seeing a dramatic growth in the waiting list like we're seeing where they've actually taken out two-thirds of access to one particular procedure; that wasn't the strategy we adopted here.

CHAIR - That busy time you had in the DEM, there was no commonality amongst those patients at all. Are you seeing, at this stage, presentations of patients who are on waiting lists whose conditions deteriorated and they've presented or is that not happening at this stage?

Ms HOLDEN - There's no change to that at all. There is no change to either the number of emergency presentations and there's no evidence that we're seeing a whole lot of surgical patients, who were previously elective, now turning into acute patients. It's kind of not surprising because what drives the emergency list is, of course, size of your population and if it grows then the incidence of trauma against that ratio and particularly an older population can do that as well, and that is not really changing for us so that is staying relatively static. And to date, again remembering this was November and we are only in early March, we are not seeing that either at this point.

Mr HARRISS - Jane, you mentioned that until you deal with the hump that is in the system at the moment you will not be able to get the two married up in terms of waiting lists and throughput. Can you deal with that in the current environment?

Ms HOLDEN - No. To deal with the hump we would need an investment.

Mr HARRISS - So with the continuing contraction, not just this year but the outer years, the clear message that I can only conclude is that the gap will grow wider and wider.

Ms HOLDEN - Yes, it will unless we can find productivity gains within what we do now.

Mr HARRISS - But earlier you indicated that you looked like pruning about $7 million off the elective surgery.

Ms HOLDEN - Yes, and that is an eight-month forecast of the program.

Mr HARRISS - Yes, but the requirement for the financial year was $10.7 million. That was the task indicated on the government list which was provided on 4 October.

Ms HOLDEN - Right. We haven't made that saving this year.

Mr HARRISS - And you won't?

Ms HOLDEN - No. We won't make that from that program, but we do believe we can with a full year in between.

Mr HARRISS - Okay. Well, next year of course that expands to a $17.3 million required saving on the Government's own list, so you are not going to achieve the $10.7 million this year and yet the gap between delivery and waiting list is still there, and you have indicated that without investment, that is extra dollars, that will grow, so how won't it continue to grow into the out years without further investment, given that the requirement to cut is even greater next year?

Ms HOLDEN - Well, as I say, I think there needs to be investment to eliminate it, but I think the factor about not letting it grow, which certainly is not shrinking it and we do have a number of patients at the boundary, will be around the way we do our business and how efficient we can be in doing our business. So I don't believe that we will eliminate the over-boundary list without investment.

Mr HARRISS - You are not going to get that investment though, are you?

Ms HOLDEN - No, so there are some other strategies that we look at, and if I could just pick one to explain what I am saying, one of our longest waiting lists is lap-banding for obese patients who want lap-banding, and what we are looking at now is putting together a model where we actually work through that waiting list with every individual and look at perhaps alternative programs for them instead of surgery, or leading up to surgery, so actually working with these patients so that they are not continuing to get more and more unwell as they wait a very long time, some of them, to access the surgery. So we are trying to look around as well, not just that because we haven't got money we've got absolutely no options. We are looking around the world, we are looking around the nation to see what innovative things are going on. With lap-banding it is a multidisciplinary team working with those patients, talking about lifestyles, working with their general practitioners, looking at what other options might be available, trying to get a program that might support those patients. Another example is all of the referral patients that come in to have hip and knee joint replacements, actually working those patients up, looking up to see whether if they had some weight loss or if they had some aids at home or if their medication was better prescribed and balanced they would in fact avoid an operation, could we in fact improve their lifestyle to the extent that they don't want an operation. And there is quite a lot of evidence that these really good programs can actually avoid up to 30 per cent of these waiting lists. So we are saying we haven't any money but we still care about these patients on our waiting lists; let's have a look and make sure that we are offering everything else we possibly can if we can't actually offer surgery at this point. There is also the benefit with those kinds of programs that you get fitter patients going into the theatre and that is a really good outcome as well.

I am not trying to avoid your question. I don't think, in a constrained and further constrained budget environment, we are going to eliminate the waiting lists. I think the potential for them to grow is there absolutely but I think we also need to take our responsibility look at alternatives to surgery and there is a team looking at those options for particular patients.

Mr HARRISS - Isn't it more than the potential for the waiting lists to grow being absolutely there, using your words, a reality?

Ms HOLDEN - Yes, I think it is a reality.

Mr HARRISS - You have indicated you won't be able to reduce them without further investment; you are not going to get the investment in terms of capital investment, you have to make some productivity gains -

Dr GOODWIN - Further productivity gains.

Mr HARRISS - Yes, further productivity gains but that is not going to reduce the waiting lists so the natural flow-on conclusion from that is that the waiting lists will continue to expand.

Ms HOLDEN - Well, I think they are not going to reduce; they could stay the same or they could expand. I am not 100 per cent clear whether they are going to stay the same or expand but I do believe they will not reduce without further investment.

Mr HARRISS - On that same theme, the requirement set for you with regard to the reduction in elective surgery volumes was $10.7 million savings then there was a range of other savings which were put to you, top down; you have made some productivity gains in other areas. Can I put to you this question: would it have been a more productive process to have engaged you, and everybody else involved, to workshop the areas of potential saving rather than deliver a bald list which says do that. You might well be way in front in many of these.

Ms HOLDEN - We are, yes.

Mr HARRISS - You are almost $4 million behind with your elective surgery. Wouldn't that have been a more productive procedure, to identify the savings?

Ms HOLDEN - Well, as I said when I opened up, we began looking at these things, just like right now we are looking at next and what opportunities we think we have got. Last year at this time we looked saying, regardless of budget we're blowing this year's so what are we going to do to pull ourselves back into line? Just like now, we are saying what other opportunities do you all think, in a multidisciplinary environment, as I am as acting CEO saying, where do you think we haven't looked and is there anything else we can do? When you say top down, those proposals did come through from us but were endorsed by the minister. When we were doing those, we were putting best-estimated numbers against each of those projects. As the years rolled out, some have done better than others but the net position was not a zero budget but a reduction in $40 million against the forecasted $60 million deficit. I think it is true to say that this would be the first year in a long time that the Royal has actually spent less than the year before.

So, in terms of the process, I did not get a project that I had not been aware of top down. No-one gave me a project from the Royal that I had not been talking about, as I say, since March 2011. I thought in some of them, there was the potential for duplication of those numbers and I was clear about that. But the STAHS projects were ones that we were working through that we rated highly likely, not so likely, unlikely. We were putting up a broad range of potentials. Again, this year just as I think every CEO is doing, we are again doing exactly that same process.

That is a process that has been going on in the north-west for quite some time, it is a process that we have been doing for last year and we are back on track doing it in the south. I am

sure the north think about their future budgets and those sorts of things as well. We were clearly in a position of coming in over budget, that was the trigger in the south.

The north-west was not and I am not so familiar with the north so I will not comment on that but in the south we could see a deficit that would not be acceptable. It was not acceptable to me as the Acting CEO and we cannot just constantly run deficits in these businesses.

Mr HARRISS - I could observe that none of that has really mattered in the past because requests for additional funding have been granted because there have been rivers of gold which have been available.

Ms HOLDEN - Certainly that issue has been a challenge from a cultural point of view, the fact that blowing the budget was no longer acceptable and had to stop right now, this year, was a big message to put across the south. Because the north-west did not blow their budget that was not the same thing but it had been a cycle of expending greater money and starting the year with that deficit being funded.

I am of the view that if you do accept a budget, you negotiate it. I am of the view that you start with the ability to negotiate it but having done that, that you need to live within those means bar some sort of pandemic that you have not clearly got the capacity to deal with - all those sorts of things.

I think it is really important that we live within our means in terms of number one - delivering the most efficient service we can to our community; and that we have got the right sort of money for next year as well. I think it is like any of us, I take that same simplistic approach that if I end up personally a year overdrawn it makes next year a bit hard.

I think it is realistic to have that view. I accept that the cycle suddenly stopped and that has created a real challenge in terms of bringing everyone on board that this is real and we do need to do this.

CHAIR - It has been hard to take the work force with you on that.

Ms HOLDEN - Yes. Not that they have not responded amazingly because they have, and a lot of people, I think, have had great ideas about how we could do things more efficiently. A number of the system's changes have been informed by the staff.

No-one has said let us cut surgery to elective surgery and no-one has said, gosh we have run out of ideas or that is the best idea, that was a really tough decision to make. I think I said to you last time the only reason we picked elective surgery was because we could. It is our view that elective surgical patients have as much right of access to public services acute but it is a flow we can manage.

I do think that that has been one of the biggest challenges and for a number of people they said, you need to go back and get more, because that is what always happens. That message has been quite a challenge but I think it is now fully understood, which is not to say that I will not be negotiating as hard as I can for as much resource as we can possibly get but that we cannot just keep blowing our budgets and expecting deficits to be

addressed each year, that is a message, clinically and non-clinically, across the organisation that is now accepted. Not liked but accepted.

CHAIR - Just going on from that, we are all aware of the lists that are published in October about the savings and, as you said, you were already on the way with even at that time. What consultation did you have with senior clinical staff as far as implementing these strategies is concerned or even looking at strategies that could be proposed to the minister? Was there any of that before the decision was published?

Ms HOLDEN - I was working with small teams. Say, if we took the elective surgery, I was working with a small part of that leadership of the directorate. They were not in a position because I was not in a position to let them go and consult widely with every part of the surgical organisation.

CHAIR - You are talking about the senior clinicians in that group, though?

Ms HOLDEN - Yes, but they were not happy about it at all but I said, if I had to do this, how would it work, what would the impact be, I need you to help me build a business case around that. So, reluctantly, and very reluctantly, they were answering my questions but I did not let them go and talk to everybody else because I was not in a position to do that because that was the instructions that we were given.

CHAIR - Who were those instructions from?

Ms HOLDEN - Via the secretary, I think, from the minister, who wanted to work through each of these plans because we put up a wide number of strategies that we were looking at.

CHAIR - But you were allowed to talk to some senior clinicians and others and at senior management level?

Ms HOLDEN - Well, I did - I do not know if I asked permission but I needed to - because remember I was there since March so a lot of things that we were doing I needed a lot of advice around and work up on things but no-one actually knew the final details of those until those went forward. They were informed but to say that they fully understood them would be a gross exaggeration.

CHAIR - Did you have any meetings yourself with the minister?

Ms HOLDEN - Yes.

CHAIR - In those meetings, what sort of instructions were you given?

Ms HOLDEN - I recall talking about the fact that I felt consultation should be broader; that there was a lot of angst in the sector, that people knew some things; I certainly had not sat in my office and just come up with some numbers - so there was a level of understanding in the organisation and I felt we needed to talk more openly about the fact I felt that their frustration would result - I do not think we can manage that. The minister acknowledged that. She felt that the budget cuts were coming from her ministry and that

she would, with huge regret, announce those rather than asking us to do that. That was my understanding of that strategy.

My response then was let's do it real soon then because we need to get these and deal with the facts and not allow rumour to grow and everyone to get very nervous about what we are doing.

Mr HALL - Jane, - you may have already answered this - but the document you tabled on the statistics, referring particularly to the Royal Hobart Hospital, the top one, it gives the awards and the categories for awards. If you look at that period that goes from 2008 through to 2012, then most of those awards, basically the numbers, the establishment of personnel flat line, except the top one; the admin and clerical, which really is a big winner, if you like - probably about an 80 per cent jump between 2008 and 2012.

Ms HOLDEN - I can't answer anything beyond 2011.

Mr HALL - No. It stands out as about an 80 per cent increase.

Ms HOLDEN - Well, some people have changed from awards. The difficulty with charts like this is that the data behind them is incredibly important so some people may have moved from one award to another award, which makes it look like we have more people but in fact we have just got more people in that award. Some of them might have been coming through because we have taken on new services or services have gone; so in 2008 I think mental health was part of STAHS and there have been changes in how we have organised the system.

Mr HALL - Right. I would have thought that they were fairly specific categories, that they wouldn't cross over - I may well be wrong - into admin and clerical, for example.

Ms HOLDEN - No, there are some changes in that regard. They might have stayed in the same union but they have changed from operational to clerical staff.

I think the useful table - and I am sorry because had I known to answer the question - is from 1 July 2011, which is this year of the budget cuts, to where we predict to be on 1 July 2012.

CHAIR - Getting back to what Greg was saying, and I know you can't really comment because you work down in the south at this time, but in 2008 we had budget management strategies where there were going to be significant reductions to the public sector - I think 800 positions were talked about at the time - and Health being one of those people-focused areas, we are seeing here an increase in these areas, particularly the clerical and administration area when there was an expectation that numbers would fall and costs would be reined in. The nursing and medical staff, through the medical practitioners award, we have to look out to find the figures. On 1 July 2010 it dropped to 314 from 322 the year before.

Ms HOLDEN - The Royal Hobart Hospital?

CHAIR - Yes, I was looking at the Royal.

Ms HOLDEN - Again, it might be where some staff members have been counted in one year and not counted in the other. If you look at medical practitioners, 314 in 2010 to 343 in 2011 to 386 in 2012, that is a growth by anyone's standard. I tried to explain that in some areas, and medical was one area, we have actually increased the number of FTEs by decreasing, and in doing so decreasing the cost, for instance of overtime. We have honoured our commitments to training and those sorts of things.

CHAIR - But there is also that increase in the clerical area. The Premier recently came out with an explanation of the additional spending over the last few years and laid it pretty much at the feet of Education and Health. We are not only seeing nurses and doctors here, we are seeing administrative and clerical staff also.

Ms HOLDEN - I think there is a lot more behind this. In some ways I regret tabling it because I want to understand some of the detail behind it and as each ward is negotiated. I don't have enough background to share with you how that is; I am perfectly happy to write back to you something about those numbers. I think without that this could be misleading.

Mr HALL - I would be happy if we got a bit of background on that. The SES in 2008, there were two and now there are five, which is a reduction of one. There are five now, is that -

Ms HOLDEN - In the southern Tasmanian area there were five positions that were SES level.

Dr GOODWIN - Jane, you have mentioned 'pandemic' a couple of times, is that the only major risk to a further budget blowout or are there others?

Ms HOLDEN - Look, I mentioned it in terms of bed capacity to deal with something like a pandemic where there wasn't bed capacity. I mentioned it in terms of current budgets, those sorts of pandemics where you have to mobilise all sorts of additional staff and you still have to cover your base in that regard. No, it is not the only thing. We could have some major trauma, some really significant trauma that we have not budgeted to address. We could have a growth in acute demand that is higher than the previous growth. Sometimes, just like the last two weeks, you can't find a good reason for it, but the fact is more people needed admission than others. You could have a bad year. We could have a very cold winter and have a much bigger demand on beds in our winter period. We do have the capacity to flex elective, but we really do not want to reduce much more access to elective if we can help it. So there are a number of factors that could put additional pressure on the system.

Dr GOODWIN - And that is hard to predict, obviously, whether one or any of those should occur.

Ms HOLDEN - But when we look at our planning we do take averages, so it would be out of the norm of the average of the last couple of years sort of approach.

Dr GOODWIN - I just wanted to ask about sick leave, because that is one of the savings strategies around annual leave management. How is that tracking at the moment?

Ms HOLDEN - It has been a focus of ours all through this year and it will stay the focus. I have put in a target of sick leave on average across the organisation of 3.5 per cent. Some areas do very well; some areas don't do so well. In fact to reach that target, just so it is kind of understood, if every employee took one day less sick leave per year we would hit that target. In fact we would be just a bit below that target, so it is not so out there if you know what I mean. We definitely don't want staff to come to work unwell, that is not the strategy at all, but we want to develop a culture that really means that staff do come to work if they are well. So there is a lot of work going on around building an environment that is valuing the employees, particularly across areas where there are high sick leave levels. Shift workers have a higher likelihood of being unwell, just the whole nature of it. They are in environments full of sick people, that happens as well, so to think that we wouldn't have sick leave is crazy, but we want to engage a whole lot more with those people that might be taking lots of sick leave or those departments where sick leave is at a higher rate. All of that is about building up an environment of employee value, and also working particularly with those staff, some of whom think we haven't even noticed or nobody cares or some of that sort of stuff. So it is going okay. In some areas we are doing better. We have just had a blip with vomiting and diarrhoea ripping through the place, so we go up.

Dr GOODWIN - The Tassie Tigers are suffering.

CHAIR - They probably brought it in.

Ms HOLDEN - Anyway, it is a long-haul strategy because it is not just about sick leave. It is about all of the things that surround. Sick leave can be an indicator of a whole lot of things, so we want to work with all of the heads of departments to work through those issues, engage with staff and give people skills around how they talk to staff that are unwell, and how do we support them to come back and all sorts of things.

CHAIR - Just on that point, does that include any stress leave that is classified as sick leave?

Ms HOLDEN - The whole lot of leave except maternity leave. It does include carers' leave.

CHAIR - Do you have an increasing number on stress leave? We are hearing from some of the clinicians and others in the community that it is a very stressful place at the moment, all hospitals. Staff morale is low which tends to lead to more sick time, generally, whether it is stress leave or other.

Ms HOLDEN - I've got no evidence that there's a greater increase in stress leave, as a percentage of sick leave at all. The EAP stuff isn't indicating that. I think hospitals are always very stressful places to work. It's the nature of the beast really.

Dr GOODWIN - Are you able to give us some sort of figure as to the number of sick days at the moment?

Ms HOLDEN - No, I can't. It's trending downwards but only slightly.

Actually, I bet that blip just in the last two weeks has murdered that trend.

Laughter.

Dr GOODWIN - Is there a blip amongst any particular section or nurses, or is it across the board?

Ms HOLDEN - We had an outbreak of diarrhoea and vomiting in paediatrics and in rehab and in one of our medical areas so there were patients and staff; it can happen.

Dr GOODWIN - Is that cleared up now?

Ms HOLDEN - Yes it is. It's clearing up right now.

We do manage those things and that put real pressure on but, again, we have managed our way through that and ensured that we have got the right staff and we're discouraging anyone who's sick not to come to work. It's had very little impact on elective cancellations or double shifts or any of that sort of thing. We've managed through that calmly.

Dr GOODWIN - What about the cost of agency staff and those things; over time. How does that look?

Ms HOLDEN - That's tracking downwards. Agency staff is dramatically downwards, particularly around the surgical area and overtime has also tracked downwards. That's been largely around those strategies to review every roster and say wouldn't it be more cost effective to add one or two FTEs to this roster and it would save us higher overtime costs.

CHAIR - Why wasn't that sort of thing done previous, Jane? That's what amazes me.

Ms HOLDEN - I can't answer that question.

Dr GOODWIN - What about locums? Is that the same?

Ms HOLDEN - The south does not use a lot of locums. Agency nurses last year - as at the end of June - we spent $1 399 000. This year we predict to spend $258 000.

Dr GOODWIN - That's a big difference.

Ms HOLDEN - Overtime for medical practitioners last year, we spent $2 573 000; locums sorry. This year we predict to spend $332 000.

CHAIR - What have you actually done to achieve that, or to seek to achieve that?

Ms HOLDEN - Well, recruitment of staff. We looked at rosters because, as I said before, sometimes everybody was looking to go off on the same time which left a gap that you had to have a locum for and putting in systems that say well, that won't work so we'll stage it and avoid that cost. The elective surgery reduction allowed us to let a number of agency nurses go who were contributing to the operation of one theatre session, in the one theatre itself. So that was a major trigger in that reduction in agency nurses.

What we really want is for people to come on board with us and be part of STAHS.

Dr GOODWIN - I still don't have a really good understanding in my mind of where the pressure points are in terms of this $20 million that you are not confident of achieving.

Ms HOLDEN - I am not confident of achieving it by June this year.

Dr GOODWIN - Right.

Ms HOLDEN - The time line -

Dr GOODWIN - It is the time line.

Ms HOLDEN - I think I said to you before Christmas something about the time line. I have never felt the time line was one that would allow us to pull that size out without doing something that might really hurt the organisation.

We took the view that this was the target and we had to look at reaching it but we also had to be here next year and the year after and the year after that so we had to make sustainable, sensible reductions in our expenditure rather than just cutting a whole lot of stuff to get to that bottom line.

I think we have done incredibly well. I think we are continuing - we have not decided 20 is enough and we are resting on our laurels - we are still putting ourselves under our own scrutiny to make sure we are as productive and as efficient as we can be around the patient but I do not think we can do more, other than keep those projects on track right now, without really good planning that would get us to zero by 30 June.

Rightly or wrongly, as the Acting CEO, I have made a call about keeping tight rein on all of those projects. Some of ours have been in place since 1 July because we started a bit sooner but some others have been November and if we measured November to November I am not quite sure where we would end up but anyway we do not - we measure November to June.

CHAIR - Having said that, if there is an amount that is basically carried over, say $20 million you seem to be expecting possibly, and it is a matter of timing, you are confident of achieving those savings but it will take longer than to 30 June, so what will it mean for the next financial year? Do you need to implement further cuts in other areas or is it a matter of maintaining its line and it will be achieved? I am just interested to know whether there is more to come or whether it is just more of the same?

Ms HOLDEN - I cannot answer that because we do not know what the budget allocations are or whether or not -

CHAIR - Because we can assume you are not going to get any more, can't we?

Ms HOLDEN - Yes, pretty much you could assume that. It really does matter about the budget though because things happen right throughout the hospital. EBAs have future adjustments in them, pricing of medical equipment goes up, all of these things matter so staying still can be a greater cost - not doing more but just standing still in this sector because that is the nature of the sector.

I am not trying to avoid the question; it is just virtually impossible to answer it until we understand what, if any, CPI adjustments are going to be available. Budget, additional budget, savings targets that could be applied to the south might be any of those things.

In terms of your question two if we got no more than last year we would have to make more savings because it costs more to stay still, you know just the price of our equipment, our sutures, our prosthetic joints, our anything, it goes up.

Dr GOODWIN - I am wondering if any of the specialists at the Royal have resigned or signalled that they might resign since the cuts started to have an impact?

Ms HOLDEN - No, none have resigned. None have resigned as far as I am aware because of the cuts. Are they unhappy? Yes, they are unhappy.

Surgeons like to operate, that is what they like to do and it does not make them happy to reduce that. They also sit in front of the patients and know that they cannot operate as quickly, and that is something they find very difficult, and I utterly understand that. To say that they are thrilled about this would be ridiculous. They have not resigned, as far as I am aware. It takes constant talking about what else would you do, how else could we live with them and that sort of engagement. We have to move to that phase of saying, this is what we have done now, what do you think we could have done differently or how else might you look at that. I just met with the nursing theatre staff last night and received some ideas about what they thought we could do that might be smarter than what we are doing now. I am not aware of that but I am certainly aware that they are frustrated and not happy with having access to theatres reduced.

CHAIR - Some clinicians have spoken out with concerns about training and accreditation being put at risk with less activity, attracting suitable specialists in the future, looking to the future as well as the current needs. This is not just in the south; it is probably across more areas than in the south because there has been a chronic underfunding of health. We have seen huge cuts taken out of it and it still seems to be functioning, in your view, reasonably well. How do you respond to the concerns of some of the senior clinicians?

Ms HOLDEN - We have committed to the training of junior medical staff. We have a commitment to 35 and I think we must honour that. That is really important. I feel a bit Pollyannaish but I do want to look for the solution rather than the problem. I think certainly this pressure has highlighted and must cause us to stop and think and say, do we have enough volume in the State to do the same thing four times and support training programs. That idea that is there an upside to constraint, not really, except that it focuses your thinking. I think it is important that we do stop and say, are there services that we really need to look at to make sure that we have the right volumes going through and have they been dramatically hit, particularly by this. Now because our approach was across all services, we did not particularly hit one service. The impact was across all of them rather than one particularly being really impacted on. But I think, as a State it has raised a very important question that I think we should be thinking about.

In terms of medical training, we have not reduced those numbers at all. In fact, we have grown them. In terms of nursing, we have made our commitment as well to the nurse graduate program. What we are really dealing with is the fact that your reputation, as it

is all negative, makes recruitment difficult. People look for jobs and they look across all of Australia and they say, I read that or I see that. I think what we now have to do is realistically, not unrealistically, look at what we are offering and look at if there is anything under threat and if there is not, then we should be really positively marketing the opportunities in Tasmania.

CHAIR - Do you think there are any threats to accreditation in any areas?

Ms HOLDEN - I think the potential exists in gynaecology.

CHAIR - Just in the south or across the State?

Ms HOLDEN - No. Depending if you cut the particular service dramatically, it could happen anywhere. It is an algorithm. They must do *x* numbers and if you close access to *y* numbers and that means they cannot do *x*, you have just threatened their training program.

CHAIR - Has gynaecology been cut, is that why there is a risk there?

Ms HOLDEN - Not entirely, in my view, but there is a population of 500 000 and let us say half of them are women then how many of those are going to need gynaecological procedures times four opportunities to provide them? That is the sum I am looking at. All I am saying is that -

CHAIR - You need to delay the hysterectomies until a bit later.

Mr HARRISS - Half a million won't need gynaecological services.

CHAIR - We have already established that.

Ms HOLDEN - I am not trying to be frivolous about that. Women must have access to services and I am a very strong advocate of that.

Let us talk about cataracts again. If you reduce the number of any specific surgery - or hips and knees - what you can do is lower the access for registrars to do that procedure enough.

CHAIR - That is what their concern is?

Ms HOLDEN - Yes. I think in the south we have not done that. There is no service where I think we have got to that point, but that was one of our other considerations in terms of how many sessions we cut by service and for us and gynaecology, even though their waiting lists were shorter, the risk to the training program was higher, so the cut was less.

Mr HARRISS - While we are on surgical and theatre throughput et cetera, has the capacity of the Royal with regard to theatres been expanded over recent years?

Ms HOLDEN - No. Ten additional sessions were opened, I think about 18 months or maybe two years ago, although the funding for that was not complete. I think it was called the 'night theatre', is that what you are referring to?

Mr HARRISS - I'm thinking of extra capacity being made available in the last three or four years.

Ms HOLDEN - Yes, 10 sessions a week.

Mr HARRISS - You have just indicated that the funding was not delivered to provide for that identified expansion.

Ms HOLDEN - Not all of it, some was.

Mr HARRISS - How many extra?

Ms HOLDEN - I can't give you an exact number but there were enough surgeons and anaesthetists for the full 10 sessions but there were a number of gaps in the nursing funding for those and some of the deficit by the end of June was related to using agency nurses to support, in addition to the budget, keeping those 10 sessions open.

Mr HARRISS - How many sessions are open now across the hospital?

Ms HOLDEN - There are 20 day-procedure sessions, 40 elective sessions and 20 emergency sessions a week.

Mr HARRISS - How does that compare to the capacity of theatres?

Ms HOLDEN - There are 23 sessions closed.

Mr HARRISS - Per week?

Ms HOLDEN - Per week. Right now one of the models we are looking at with our national partnership funding is increasing up to another additional 10 sessions for some day surgical procedures.

Mr HARRISS - So with 23 closed at the moment, when were they closed to that extent?

Ms HOLDEN - November.

Mr HARRISS - So almost immediately upon -

Ms HOLDEN - That was the strategy.

Mr HARRISS - Was that supposed to deliver you savings of $10.7 million?

Ms HOLDEN - Yes, that was our estimate and the plan we were working up to be able to get the rest of the savings strategies out there. In actual fact not everything kicked off on that day. I think that strategy was 1 October but we did not implement it until November. In some things we have saved more on that strategy and some things we have saved less, so it is a matter of getting theory to match reality. The delay was also complicated by the fact that we are in the middle of doing some pretty major capital works at the Royal, so we also had to work our way around some major capital projects

to allow us to get the right kind of ward precincts there that would support this sort of strategy as well. So all of that delayed that by about a month, and then some areas we have overestimated and some we have underestimated.

Mr HARRISS - Given that you are likely to fall short of your savings target by $20 million, I suppose my first question would go to the point of what is the reporting procedure to your minister as to your aggregated savings. Is it monthly? Is it weekly?

Ms HOLDEN - We report monthly. I report through the secretary, not to the minister.

Mr HARRISS - And, given that you would have identified that likely shortfall, what has been the reaction? Is there a requirement to ramp up some savings elsewhere, or close other surgery services to achieve -

Ms HOLDEN - There is not a month goes by where that discussion is not held, and I think it is pretty well understood that it is not not being taken seriously. But, as I said to you before, I do not believe at this stage the capacity in the Royal to even think about another project exists right now. We have to bed down those things so that the savings we have made are actually sustainable. You can't just save it one year, because it has to be sustainable, and that is the sensible thing for us to do, but I assure the secretary that we are doing everything we can possibly do to make sure that every saving we can get we will achieve, but that I do not believe reducing any further access to our patients is the right move at this time, or closing further beds.

Mr HARRISS - Given that you can only speak, Jane, of recent years of involvement, have you had any discussions with senior staff as to - we are going back to things we were discussing a little earlier but maybe not the specific detail - what measures were put in place for efficiency dividends that Greg and Ruth spoke about earlier, and as to why they were not achieved then? And whether ministerial accountability was required at that time?

Ms HOLDEN - I am sorry, I am not quite sure. Do you mean have I had any discussions with staff about how we have made this 40 -

Mr HARRISS - No. You are achieving some efficiency dividends.

Ms HOLDEN - Well, everyone is. I am certainly not doing it on my own.

Mr HARRISS - Yes, sure, but in the 2008 financial year, I think it was, when the global financial crisis was looming, the then Treasurer and Premier made it very clear that every department would be required to achieve efficiency dividends. Most were not achieved. We were just looking at employee numbers a while ago. Let us not focus on that, but the bigger picture. So in terms of comparing what you are doing now, what you are all achieving, there was not an achievement. Have you had discussions with senior staff to compare the two, to say 'We were required back then, why didn't we? We are now. Why the hell couldn't we have done something back then and we might not have been in such a parlous situation?'

Ms HOLDEN - Well, I wasn't in the south, I was in the north-west and the north-west achieved their efficiency dividends every single year. I guess the only conversation I

have had about that - because I am one that wants to learn from history, I don't just want to be captured by it - if people have said to me this should never have happened; it is someone else's fault or someone is doing something wrong, what I say is that to some extent we have to own this, and here is the history of the expenditure year on year. At the end of the day we are at this point now, and if it feels good to blame someone on the way, well, but here we are today. So what are the things that we can do today? And they could well be different from things that could have been done or were done and maybe did not deliver as much. My focus is really where we are at today and what, having worked in the organisation sometimes 20 years, sometimes with fresh eyes for a year or something, do you think we could do differently that would make the dollars we spend have more impact on our patients or cost less to do exactly what we want to do now? So, no I have not sat back and said well, look at us today and look at you then. I do not know what that would achieve. But certainly a number of clinical staff have been really positive in providing ideas about how we could make some savings. As I say, not one of them said let's close the operating theatres. The savings are not there - so I think that they have come to the table quite proactively around where they feel the system could be improved to save some money. Certainly, one of the big things that we do is making sure that we are turning any bit of data into information so that everyone is looking at the same thing all of the time. We have agreed key performance indicators so everyone is kind of aware of where it is that we need to go and trying to share the challenge that we have right across the organisation. That, again, is not a quick fix; it is a long haul process about engaging everyone, people not being surprised, people understanding some of those challenges and coming on board from today into the future rather than looking backwards.

I think if you look back everyone just remembers the good old days but I was around in the good old days too and they were not so good.

CHAIR - I was too.

Mr HALL - On the performance indicators, Jane, you mentioned them now being instituted. So, are you saying, there have not been any in place in the last few years? I know, historically, you have only been there for a short time.

Ms HOLDEN - Yes. Well, I honestly cannot answer that but I took our commitments we had made, either through a national partnership agreement or quality standards, health standards of Australia or some of those things and we worked through with heads of department and whole teams of people who are leading the organisations asking which of these are real priorities, which are the things that we think we should be working towards and do we all agree that those are the things that matter to this organisation. Then we said, if we achieve those, would we get to the position we want to get to. That has been my approach. Others have different approaches to doing it; mine is - and I am sure you could go back last year and previous years and people would have said this is what we are trying to achieve, I guess. What I am saying is we will try to sign them up across the hospital and get back to each other but I certainly could not tell you that they did not exist before and I can tell you that they do now.

Dr GOODWIN - Could I ask about the occupancy level of the hospitals since the budget cuts started to take effect?

Ms HOLDEN - Again, the Royal has a pretty high occupancy and it always has. Prior to the budget, with the bed reductions, it had a high occupancy. In actual fact, we have had pretty low occupancy as it so happened we got through November, December and January with sometimes 50, sometimes ??[4.38.53] bed. Today we had 26 beds available but at times we can be under really big pressure and at other times things flow very well. Again, it is about the reality of what happens on one day as compared to what happens across the month. It is too soon to tell you that the occupancy has gone up because, in fact, the trend is it has gone down because November, December and January were pretty light but February has not been and we have had some pressure now but, as I say, today when I look at it every day we have 26 beds -

CHAIR - How many beds have you got all up?

Ms HOLDEN - I think it is 387.

CHAIR - It is still a fairly high occupancy.

Ms HOLDEN - It is circa 387, I would hate to depend on that, for surgery. I do not know why I could not say 385 but I am pretty sure that is the number. We have a pretty high occupancy and those beds are churning through.

Dr GOODWIN - How many beds have actually been closed all up?

Ms HOLDEN - When we have completely finished this, which is March, it is 26 beds.

CHAIR - Some of them are closed now, though?

Ms HOLDEN - Yes, we have 22.

CHAIR - So you have to add four more?

Ms HOLDEN - Yes. There are some closed and others open where we extend the OPU so it is a bit of a balancing act of the net reduction.

CHAIR - One of the things you have probably been aware of has been discussed by most people is the funding model and the lack of one single funder. Do you have a view on that?

Ms HOLDEN - If I took a simplicity approach, if I said simple is easier to manage, one is simpler. I think there are a thousand ways to skin a cat, so as long as it is kept simple and not made enormously complex, the fact that the money comes in from two funnels and ends up in one place you can live with, I think.

CHAIR - But it is not quite as simple as that, is it?

Ms HOLDEN - No, it is not, but we have to keep it simple. It is a simpler system with a single funding model.

CHAIR - With the changes under the National Health Reforms, do you think that will simplify it at all?

Ms HOLDEN - It does not simplify the funding model because there are still two funders. I think it makes it more transparent in that for a large bulk of what we do in hospitals we are being paid on an activity-based arrangement, so you get paid for what you do. I think that will make it more transparent in that regard. I do not think it is the panacea solution to everything but I think it provides a clearer environment. I think there is still a number of services for which the funding methodology is unclear and I am concerned about how quickly that is going to be clarified moving forward.

CHAIR - In the reform process, you mean?

Ms HOLDEN - Yes, in the reform process.

CHAIR - Specifically those areas?

Ms HOLDEN - I think we are still a little unclear around dental and mental health. Disability is still not quite so clear.

CHAIR - Views have been expressed quite strongly by some stakeholders that the only way to fix the health system in Tasmania, because it is completely broken, is with a single funder and that will fix everything. Do you agree with that?

Ms HOLDEN - No, I do not think that will fix anything. I think there is always a myth in Health that we love to think we have the Messiah that will fix Health, and it is always one thing, and of course it is never going to be one thing. I am probably far more interested in how the provider side of this equation works together and how well we work with each other and through primary, secondary, tertiary linkage that we get those things right. If you thought you would just fix the funder bit, you did not look at making sure all that worked, then you would not have fixed the whole thing at all. I am a strong supporter of an integrated health system.

CHAIR - I know you have done a lot of work in the north-west around that, and I am sure you are doing what you can down here to achieve that, and I know you have budget constraints at the moment, but what do you think is the most important thing we should focus on to achieve good patient outcomes and as good an access as we can expect?

Ms HOLDEN - You want the Messiah answer.

CHAIR - Yes, bring the Messiah in and ask, 'What do we need to focus on within the budget we've got?'

Ms HOLDEN - It is not one thing, but I think we do have to focus on - and I am talking about a provider thing and that is where my competencies are - I utterly accept simplicity; I want simplicity from the funder model. If someone said, 'You've got to go and fix it', I would want to look at how we are managing chronic disease across the State; I would want to make sure that there was real work going on where we were looking at devolving work that could be done as safely and probably as more cost effectively for that cohort of our community that need it from the hospitals to the communities, so that we are building capacity in the primary health sector to deal with that to avoid all these patients coming to hospital because they are better managed in that area.

CHAIR - Would that be building the capacity of the nurses as well?

Ms HOLDEN - It is building the capacity across the sector so it could be building the capacity of the nurses to work out in the community; it could be using technology and telehealth to have clinics so you are not bringing all the patients in. You are actually having the guidance from perhaps one physician seeing a group or not having to be there so it is a saving on travel.

People do not get chronic diseases, they get them in the way they live their lifestyles in their communities. Sometimes they are genetic but we deal in hospitals well with the acute exacerbation but what we need to do is deal well in the community with managing and mitigating as much as we can the risk of chronic disease. I see that as a really important focus if we want to have a sustainable health service because if we do not do that that tidal wave is pretty big. We are the oldest State and it is on its way.

CHAIR - The focus around the cuts is all on the hospitals pretty much and it has been said that primary health could be next and some of the rural hospitals and places like that. You were saying there is a need to keep people out of hospitals and it is pretty clear that that will help ease the pressures. If the primary health services are next in the gun -

Ms HOLDEN - Well, I am talking about the primary health sector, I am talking about the primary health team - not necessarily the district hospital but the primary, the whole lot.

CHAIR - Yes. The rural hospital is only part of that I suspect as part of the example.

Ms HOLDEN - I am not even necessarily talking about a hospital at all. What I am saying is let us build capacity in that team to be able to support their patients with chronic disease to avoid hospital admissions and what would we need in the community to allow that to happen.

Sometimes that is more access to a consultant, so what about sometimes they are part of that team. Sometimes it is about developing stronger programs, better IT systems so that we are sharing information all the time so people are not waiting for results or something. There is a lot we can do in that area. That is the area, I cannot give you one, two, three - we could spend three days here and I could tell you what I think about this - but I absolutely believe that that is an important part of a future strategy that allows the Health budget to be sustainable.

CHAIR - You are talking about investing in that, are you not?

Ms HOLDEN - I am talking about perhaps devolving some resource there so it is a movement of resource rather than additional investment. I really think that idea of working with our patients so that they understand that coming to a hospital does not cure them if they have a chronic disease because of how they are living; we have got to get those messages across.

We have really got to do some better work and that is the sort of work we were doing in the north-west a lot with the councils and others stressing where a big difference can be

made, and it is actually with the patient and their lifestyle, not with the hospital or anything else.

That is where I really think hospitals are very expensive so I think they have to be very efficient and I think that is a good strategy that we should always be looking at how we are doing things and not duplicating. I would want, and really like, systems such that if someone said you could create the perfect health system you would have it designed around patient pathways and primary and secondary and tertiary and quaternary well linked and technologically talking to each other, and actively talking to each other as well, sharing the same sort of a vision would be fantastic.

CHAIR - One system for the State.

Mr HALL - I would like to clarify your view on - I think the Chair's question was - a single funder. It has been put to us perhaps the Commonwealth ought to do that because they have the capacity to raise taxes basically. Given that health costs are going to go up probably exponentially over the next few years for all of us, then is it your view that perhaps the Commonwealth should be a single funder given that they have much more capacity to raise revenue than the States, and would that matter if that was the case?

Ms HOLDEN - Would it matter to me as a CEO?

Mr HALL - Yes.

Ms HOLDEN - I do not mind where the money comes from. I am pretty agnostic about where the money comes from. I think the assumption about this is that if the Commonwealth was to fund it there would be more money and that is the issue for me, the one I would want to test.

CHAIR - They have budgetary problems, too.

Ms HOLDEN - Yes. What I am saying is no, from a CEO's point of view, I am pretty relaxed about who puts the money in the bank but I think the issue around that is what does that mean in terms of local, how do you then negotiate outcomes and those sorts of things?

Mr HALL - I realise there are other flow-on effects from that. Remember, we have a very small model of the Mersey obviously here.

Ms HOLDEN - I know that one very well.

Mr HALL - Yes, I know you do. It just seems to me that we have anecdotal evidence from other professionals and organisations, and some of them have a strong view that is the funding.

CHAIR - That is the Messiah they think.

Mr HALL - Yes, maybe so.

Ms HOLDEN - I think the demand that we can foresee has the potential to make Health almost eat up any other of the vote in our Treasury's money and that is why I am so keen that we start doing some other work. I think that because people can look at it and see that, and in a small State like Tasmania with the oldest population see that realistically, then we jump to let us have the Commonwealth as the funder but, as I say, that goes with the assumption that will mean that the State can get on with all of this other stuff and not be facing that kind of pressure from one aspect of its problem, responsibility for Health. I do not know how it would work. I do not really mind who funds us so long as the funding is available or that we have realistic time lines to address it.

Mr HALL - Human health is more than one-third of our State Budget; I think it is something like 35 per cent or thereabouts at the moment.

CHAIR - Health and Human Services.

Mr HALL - Yes, and given that we are a small State do you think that some other States have other aspects to their revenues, like Western Australia, et cetera, with mining revenues and royalties and that sort of thing, do you think then Tasmania could possibly be a model that the Commonwealth might pick out and try it here to suck it and see?

Ms HOLDEN - I think Tasmania could be a fabulous model for a number of innovative health chained models, and funding could be one of them but, as I say, I am particularly interested in the provider side because that is obviously where I work and what I do. But I think the size of Tasmania and the fact that it does have urban and rural, that it has the oldest ageing population, that it has a microcosm of a bigger issue; I think we are in a wonderful position to offer pilots. We would need investment to do that but I think we are in a great position to do that.

Mr HALL - There is going to be a cost, though, in resources and cash to do that. I accept what you say that it would be perhaps a great chance to do something like that. Who would fund that?

Ms HOLDEN - Again, I got my two but I think the Commonwealth would be a good - and I don't think the State can afford to so I think the only other option is the Commonwealth but if you were looking for somewhere to do something I would say we should have our hands up.

Mr HALL - And take a lead from some other jurisdictions in the world in this respect, in a westernised country not a developing nation where they have different matters, different -

CHAIR - Expectations.

Mr HALL - Yes, very much so.

Ms HOLDEN - Yes. We are not third world or anything like it, so it would be silly. But I think there are people in here in Tasmania who have some fabulous ideas if that was something that the Commonwealth was interested in doing. I would certainly be hoping and promoting, as far as possible, Tasmania as just that place.

CHAIR - One of the issues with the single fund is the competition that goes on under our current arrangements and I think it was Gavin Austin talking about the *Gray's Anatomy* approach to assessment of patients and having two, three or six of those as far as investigative assessments whether it be pathology or radiology or whatever it is and, depending on where those tests are done, the cost burden falls. We are often seeing tests being repeated because there is a lack of communication.

Ms HOLDEN - That was all that connectiveness I was talking about. But that is not necessarily the funder, sometimes that is the way we behave in the provider world as well.

I just want to leave with you that there are two sides, there is the sky and the earth, the funder and the provider and they have to work together. I think we would be disappointed if we change just one, just the funder without the other. I think there is probably more gain in changing the provider than in just changing the funder. But I think doing both would be exciting.

Dr GOODWIN - Can I ask a final question on the Royal Hobart Hospital redevelopment and what that will mean in terms of beds, will there be more of them?

Ms HOLDEN - Yes, there are 195 new beds that are being built. There is not the operational funding to support those but there are more beds and on campus there will be more beds. So we need to work over time to within the contracts to support using those beds if they are needed.

Dr GOODWIN - Meaning contracts from the Federal fund or the local -

Ms HOLDEN - It will be both - the local funding which enjoys funding from the State and the Commonwealth.

CHAIR - So it will now be a hospital with no patients until we can fund the nursing care for the beds.

Ms HOLDEN - Sorry, say that again?

CHAIR - Until you can provide the support for opening the beds, it will be the new wing with plenty of beds but no patients.

Ms HOLDEN - There will not be an empty new wing, I can assure you of that. I think the reality of that is that I do not believe if we opened them tomorrow that we would need 195 additional beds. There is just no evidence to support that. This is stage 1 of a future-oriented development and it is about looking to the future and those things.

Dr GOODWIN - Projected demand for the ageing population?

Ms HOLDEN - Yes and moving forward and one of the things that we are doing here is in creating these new environments we are, for instance, in ICU, instead of working in a space of 13 metres around the bed, we are moving to 20 but new hospitals are building 24. But what can you do? We can manage the care a whole lot better. In the new building we a co-locating things so that we get efficiencies, so we are driving

productivity just by having those beds. So the potential for more patients and the same number of beds is greater because you can be more efficient. What we have now is something loved and known as the 'safari rounds' as huge numbers of people walk all around wards and get their patients and find their patients all across the hospital. In the new design that will not be the case. Those sorts of gains are hard to quantify but in time we can quantify them and then you would just look at how many patients you could see if you were not taking half a day to go and see the ones you have.

I am not trying to make it longwinded. I think there are real gains in this that are going to increase access without necessarily opening additional beds but there certainly will be more capacity.

CHAIR - Thanks for that Jane, I appreciate your time again. It is nice to have you in person as opposed to a voice coming out of a black box.

Ms HOLDEN - What sort of time line do you have for getting you a paper back on FTEs?

CHAIR - We might have to confirm that, and as soon as you could provide that - basically tomorrow.

THE WITNESS WITHDREW.